RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CR243

Co-occurring substance use and mental health disorders (CoSUM)

May 2025

COLLEGE REPORT

Contents

About this report

This report was developed by RCPsych's working group on co-occurring substance use and mental health disorders.

Members of the Working Group

Professor Owen Bowden-Jones (Chair)

Dr Luke Baker
Rachel Bannister
Dr Edward Chesney
Dr Karim Dar
Dr Edward Day
Dr Jenny Drife
Dr Emily Finch
Dr Anna Fryer
Dr Stephen Kaar
Dr Nicola Kalk
Melinda King
Dr Cressida Manning
Dr Jan Melichar
Dr Donna Mullen
Thomas Rutherfoord
Dr Shivanthi Sathanandan
Professor Julia Sinclair
Dr Iain Smith
Dr Georgia Templeton
Dr Derek Tracy
Dr Anto Varughese
Dr Killian Welch

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Foreword

"The most important question is not 'why the addiction' but 'why the pain?' In order to heal addiction, we must look at the underlying trauma."

— Dr Gabor Maté, renowned addiction expert

"We do not choose to experience addiction. And it is never our fault we become addicted to an addictive substance. We have underlying trauma, suffering and pain. Like most people, we have struggled to cope with our thoughts and emotions. Whether we know it or not, we have a void inside ourselves we are trying to fill. Whether we have been harmed by adverse childhood experiences and significant traumatic events such as abuse, or those sometimes described as "trauma with a small t" (e.g., bullying, illness), or systematic inequality and poverty, we have suffered - and go on to suffer further through living daily in addiction. Perhaps a question professionals can most usefully ask themselves is how might it feel, to walk a day in these shoes?

Due to the impact of living day to day with an addiction, those of us in this situation, by its nature, are not experiencing good mental health and wellbeing. High numbers have underlying anxiety and/or depression which is worsened in the cycle of addiction, and others have additional and significant mental health conditions. There is a complex, interwoven, symbiotic relationship between addiction and mental health – hence the principles of "no wrong door" (not pushing people between services), and taking a holistic approach to treat the whole person, are so vital.

It is important to understand that many of us will not fit the stereotypical image of what a person in addiction is perceived to look like. The authors of this introduction were dismissed by services for being in turn "articulate and resourceful with family support', and as a "binge-drinking student" (despite drinking daily from 10am) – delaying treatment and causing years of additional unnecessary suffering in addiction. Addiction can affect anyone, from any background. Nobody should be turned away from help.

To any clinician reading this: You can make a huge difference to those suffering with addiction, not only through your professional expertise, but also by using what are often described as "soft skills" (which are actually specialist and crucial). These include using a warm tone of voice, eye contact and relationship-building skills to create trust and allow the patient in front of you to open up and talk to you about what is really going on. As one of the authors of this foreword describes in an opinion piece on addiction published by the *British Medical Journal,* the turning point in her recovery began when a psychiatrist looked her in the eye and said: "You just need a hand to hold to see you through this."

There is hope:
People can and do recover from addiction and go on to lead positive and fulfilling lives. But to speed up this process, there needs to be early intervention and, where possible, the opportunity to develop a strong therapeutic connection through the all-important continuity of care. Additionally, access to long-term therapy, which includes trauma-resolution approaches – some of which are described in the opinion piece referenced above, will be key for long-term recovery and healing from addiction."

Written by Rachel Bannister and Melinda King, experts by experience

Executive summary

This report focuses on the needs of people who experience co-occurring substance use and mental health disorders (CoSUM) and has identified high rates of unmet need in this group across UK health settings. Vulnerable and marginalised groups are more likely to experience CoSUM disorders and people with CoSUM disorders experience worse outcomes compared to those with substance use or mental health disorders alone. They form a large proportion of both mental health and substance use treatment populations. The term Co-SUM disorder describes a wide range of many possible combinations of different drugs (including alcohol) and different mental illnesses (such as affective or psychotic disorders). Part of the clinical challenge is that skilled assessment is needed to identify these different combinations and the clinical management and service needs will differ from one combination to another.

Health systems currently lack sophisticated mechanisms to identify and characterise the type and severity of CoSUM disorders in services, meaning that individuals belonging to this group are under-identified and there is little strategic planning in place to meet their needs.

Individuals with mental health disorders should not be excluded from receiving the mental healthcare they need on the basis of their co-occurring substance use. Instead, all services supporting people with mental illnesses should be able to provide, as a minimum, assessment of substance use and signposting to appropriate care.

Unfortunately, mental health services are currently poorly equipped to provide even basic assessment and care for people experiencing substance use disorders, including the assessment and management of withdrawal syndromes in those with dependent use. This is particularly concerning in inpatient mental health units where substance dependent patients may be put at life-threatening risk if their withdrawal symptoms are inadequately managed.

Where people with CoSUM disorders present in mental health crisis (e.g. suicidal crisis), there is currently a lack of clear pathways/protocols in place to manage immediate risk and to assess needs while intoxicated and again once sober.

While it is not the role of substance use services to provide treatment for severe and enduring mental illnesses, substance use services are currently insufficiently equipped to provide appropriate support for people with mild/moderate mental illnesses, and often have poorly developed pathways to direct people with severe and enduring mental health illnesses to appropriate mental health services. Concerningly, some substance use services have used the presence of a person's mental health illness as a reason to deny them access to substance use treatment.

There is currently minimal evidence of collaborative working between mental health and substance use services across national systems. Commissioning structures currently work against providing good collaborative care to people with CoSUM disorders as they silo working through service specifications which do not account for this group, despite them forming a large proportion of the treatment population in both services. The potential benefits of Integrated Care Systems (ICSs) in England have not yet been delivered for people with CoSUM disorders, but ICSs in theory could be a powerful delivery mechanism. In the other nations of the UK, mechanisms for supporting people with CoSUM disorders are at different stages of development, with notable examples of good practice.

This report provides recommendations on how to drive change forward.

Recommendations

For commissioners and policymakers

Trauma-informed care

Recommendation 1:

All commissioners and substance use and mental health treatment staff should receive training in understanding the link between trauma, substance use disorders (SUD) and mental health. The impact of trauma should be considered in service design and built into service protocols.

Responsibility: Mental health and substance use commissioners.

Outcome measures:

1. Evidence of completion of training (e.g. training audit)
2. Evidence that trauma-informed care has been highlighted as part of the service specification.

Monitoring

Recommendation 2:

All health and local authority commissioners should ensure that the needs of people with CoSUM disorders are addressed in service specifications, including the need for appropriately trained staff to provide assessment and treatment and routinely monitor numbers and outcomes of people with CoSUM disorders as part of contract monitoring.

Responsibility: Health and local authority commissioners.

Outcome measures:

1. Inclusion of needs of people with CoSUM disorders in strategy documents and service specifications for commissioned services.
2. Review of service performance in contract monitoring processes

Experts by experience

Recommendation 3:

All commissioners and treatment providers (mental health and substance use) should ensure that experts by experience are involved in developing and monitoring services for people with CoSUM disorders.

Responsibility: Relevant organisations.

Outcome measure:

1 Evidence of involvement of experts by experience in design of services to meet the needs of people with CoSUM disorders.

Stigma including neurodivergence

Recommendation 4:

All commissioners and treatment providers (mental health and substance use) staff should receive anti-stigma training relating to substance use disorders, mental health disorders and neurodivergence.

Responsibility: Relevant organisations.

Outcome measure:

1 Evidence of completion of training (e.g. training audit)

Recommendation 5:

All mental health and substance use commissioners should ensure that the services they commission are able to demonstrate the reasonable adjustments made for people with neurodivergence (e.g. quiet spaces, flexible appointment).

Responsibility: All mental health and substance use commissioners.

Outcome measure:

1 Evidence of adjustments made by commissioned services (e.g. national audit for benchmarking and monitoring)

For substance use specialists/services

Assessment and monitoring

Recommendation 6:

All substance use services should be resourced and trained to identify and assess common mental health disorders including anxiety disorders, depression and post-traumatic stress disorder. Further training of substance use service staff in the use of screening tools, (e.g. PHQ-9, GAD-7), clinical assessment and monitoring of common mental health disorders is needed and should be prioritised in national workforce strategies.

Responsibility: Responsible government bodies in the UK.

Outcome measures:

1. Presence of CoSUM disorders in national training frameworks
2. Evidence of completion of training (e.g. training audit)

Recommendation 7:

Management of people presenting with CoSUM disorders should be considered according to severity criteria.

- Segmentation for mental health disorders should broadly include:
  - mild/moderate mental health disorders (e.g. mild to moderate depression and anxiety), and
  - severe and enduring mental health disorders (e.g. severe symptoms of schizophrenia, bipolar disorder, depression and specialist interventions such as eating disorders, trauma therapy).

- Segmentation for substance use disorders should include:
  - mild/moderate problems (e.g. episodes of intoxication, binge use) and
  - severe problems (e.g. dependence, withdrawal syndromes)

(See the Table 1 on the next page.)

Table 1: Appropriate treatment services for CoSUM disorders by severity

Mental illness	Substance use	Example case	Appropriate treatment services for:	
			Mental illness	Substance use
Severe	Mild/ Moderate	Weekly binge-drinking and schizophrenia	Specialist mental health services	Primary care or shared care with substance use services
Severe	Severe	Daily dependent cannabis use and schizophrenia	Specialist mental health services	Substance use services
			Collaborative working between both services is essential to coordinate care	
Mild/ Moderate	Mild/ Moderate	Weekly binge-drinking and moderate anxiety	Primary care; talking therapies	Primary care or shared care with substance use services
Mild/ Moderate	Severe	Daily dependent heroin use and moderate depression	Primary care; talking therapies and substance use services	Substance use services

- National data sets to record the number of people presenting with CoSUM disorders, including measures of severity (and outcomes) in this group.

Responsibility: Responsible government bodies in the UK and NHS.

Outcome measures:

1 Revision of national data sets to better characterise CoSUM disorder presentations according to severity at presentation and progress in treatment.

2 Routine publication of UK-wide data analysing the outcomes of people with CoSUM disorders.

Treatment of mild/moderate mental health disorders by substance use services

Recommendation 8:

Substance use services should be funded and trained to provide treatment for commonly co-occurring mild/moderate mental health disorders (e.g. mild /moderate anxiety and depression). Available interventions should include psychological (e.g. psychologist-led cognitive behavioural therapy and trauma therapy, either in-house or in collaboration with Talking Therapies) and pharmacological interventions (e.g. prescription of anti-depressant, anti-anxiety medication, either in-house or in a shared care approach with primary care). Responsible government bodies in the UK should provide updated guidance on the expectations of substance use service to manage co-occurring mental health disorders of different severity.

Responsibility: Local commissioners should clearly describe in relevant contract specifications the expectation that services will assess and manage commonly co-occurring mental health disorders either in-house or in collaboration with local services.

Outcome measures:

1. Responsible government bodies in the UK to publish revised guidance for substance use services on CoSUM disorders.
2. National availability of mental health interventions provided by substance use services (including in collaboration with other services) should be routinely monitored and published by services.

Recommendation 9:

All substance use services should have an agreed pathway to specialist mental health services for supporting people experiencing severe and enduring mental health disorders (e.g. schizophrenia, bipolar disorder, eating disorder, post-traumatic stress disorder, severe personality disorders). This pathway should be regularly audited to assess how many referrals are accepted/declined by mental health services and the reasons for declining.

Responsibility: Substance use services and mental health services.

Outcome measures:

1. Available pathways and joint working protocols between substance use services and mental health services.
2. Monitoring of use of this pathway including recording of accepted and declined referrals by mental health services to be routinely published.

Recommendation 10:

Substance use services and mental health services should consider options for collaborative care for people with CoSUM disorders. This could include a community of practice approach, joint working protocols, joint multi-disciplinary meetings and provision of substance use liaison in-reach services to mental health inpatient settings.

Responsibility: Substance use services and mental health services.

Outcome measure:

1 Evidence of joint working should be documented in performance reporting to commissioners by both substance use and mental health services.

For mental health (non-substance use) specialist/services (including inpatient and community)

Assessment and monitoring

Recommendation 11:

Mental health service staff should be sufficiently trained to provide basic assessment of substance use disorders including identification of dependence and withdrawals. The ASSIST-lite is suggested as the best screening tool to support this assessment.

Responsibility: NHS providers of mental health treatment.

Outcome measures:

1 Completion rates for ASSIST-lite recorded on national data sets.
2 Evidence of substance use disorders as part of national mental health training frameworks
3 Evidence of completed training on management of substance use disorders by mental health workforce (e.g. training audit)

Recommendation 12:

All mental health providers should have an identified "Addiction Tutor" who is recognised by national networks to ensure that all psychiatric trainees have access to an addiction tutor to assist in completing their training portfolio.

Responsibility: All mental health providers.

Outcome measures:

1. Availability of addiction tutors in each region.

Treatment

Recommendation 13:

All mental health staff should receive training to assess and deliver brief intervention and harm reduction advice to people with CoSUM disorders, with specific focus on alcohol and commonly use drugs.

Responsibility: All mental health providers.

Outcome measures:

1. Increased number of staff who have completed training on delivering brief interventions.
2. Increased number of brief interventions delivered.

Recommendation 14:

All mental health inpatient services should be trained on delivering and have clear protocols on the following:

a. Alcohol detoxification
b. Benzodiazepine detoxification
c. Management of stimulant withdrawals
d. Opioid detoxification
e. Re-initiation and/or continuation of OST in those with known opioid dependence who are currently/or recently being prescribed OST.

Responsibility: All mental health providers

Outcome measures:

1. Availability of detoxification protocols on providers' information systems.
2. Evidence of training on detoxification protocols delivered to staff.
3. Audit of management of people with substance use disorders on mental health inpatient units, using the College's POMH audit as a baseline for alcohol

Recommendation 15:

All mental health inpatient services should have a discharge protocol specifically aimed at reducing the risk of relapse for people with CoSUM disorders. This should typically include supporting referral to substance use services, checking on post-discharge engagement with substance use services and signposting to community resources to support substance use disorders/abstinence.

Responsibility: Mental health providers.

Outcome measures:

1. Availability of discharge protocols for people with CoSUM disorders
2. Improved discharge planning for people with CoSUM disorders including better engagement with substance use services (where indicated) measured by audit
3. Reduced relapse to substances post-discharge from mental health inpatient services (where measurement is possible).

Recommendation 16:

All mental health inpatient services should provide take-home naloxone to people with opioid dependence or those at risk of opioid use. Community mental health services should be able to direct people to take home naloxone suppliers as indicated

Responsibility: Mental health providers.

Outcome measure:

1. National audit of provision of take-home naloxone at discharge from inpatient mental health inpatient wards allowing for comparison between units.

Pathways

Recommendation 17:

All mental health services should have a protocol for accessing advice from substance use services. These could include substance use liaison workers, joint working protocols, use of liaison substance use services. For mental health **inpatient services**, this should be available at all times to ensure that people with substance use disorder, who inpatient staff have been unable to stabilise, have access to expert care.

Responsibility: Mental health providers and substance use services.

Outcome measures:

1. Availability of substance use expertise to mental health inpatient services.

For the Royal College of Psychiatrists

Policy

Recommendation 18:

The Public Mental Health Implementation Centre (PIMHIC) should ensure that the needs of people with CoSUM disorders are incorporated into the broader public mental health agenda.

Responsibility: Public Mental Health Implementation Centre and College oversight.

Outcome measures:

1 Evidence in policy documents that the needs of people with CoSUM disorders are represented
2 Addictions Faculty involvement in PMHIC work programme.

Recommendation 19:

The College Centre for Quality Improvement (CCQI) should be commissioned by RCPsych to undertake a UK-wide audit of the current provision of services for people with CoSUM disorders leading to benchmarking, identification of best practice and the formation of a community of practice clinical network.

Responsibility: CCQI, with College oversight.

Outcome measure:

1 Publication of audit of provision and quality of services for people with CoSUM disorders.

Recommendation 20:

The Royal College of Psychiatrists should work with the Care Quality Commission (CQC) in England and Wales, the Regulation, the Care Inspectorate in Scotland and the Quality Improvement Authority in Northern Ireland to ensure that inspections of mental health and substance use services include measures relating to the training of staff and the provision of services for people with CoSUM disorders.

Responsibility: Royal College of Psychiatrists, CQC, Healthcare Inspectorate Wales, Care Inspectorate Scotland, and Regulation and Quality Improvement Authority.

Outcome measure:

1 Evidence that inspections include measure of the needs of people with CoSUM disorders.

Recommendation 21:

The Royal College of Psychiatrists should work with other national stakeholders to ensure that training materials on the assessment and management of CoSUM disorders are available for psychiatrists and other mental health professionals. This should include exploring the development of credentialling in the management of substance use disorders for psychiatrists who do not have a General Medical Council (GMC) endorsement in substance misuse (addiction) psychiatry.

Responsibility: The Royal College of Psychiatrists in collaboration with other national training stakeholders.

Outcome measure:

1 Availability of a range of training opportunities on assessment and management of CoSUM disorders

Chapter 1: Introduction

People experiencing co-occurring substance use and mental health (CoSUM) disorders are a high priority for the Royal College of Psychiatrists, clinical services and policy makers. This group has poorer physical and mental health, poorer social and occupational functioning, poorer treatment engagement and outcomes, and poorer mortality rates compared to those experiencing either a mental health or substance use disorder alone.

As this report will demonstrate, there are complex interactions between substance use and mental health disorders, worsening the outcomes of both conditions. Co-occurring mental health and substance use disorders encompass a wide variety of clinical scenarios, including alcohol and anxiety, opioids and depression, stimulants and psychosis and sedatives and post-traumatic stress disorder.

This is not a small problem or a small group of people. Between a third and a half of people attending mental health or substance use services experience both substance use and mental health disorders, but this often passes unrecognised leading to a missed opportunity to deliver appropriate interventions. Fortunately, there is a firm evidence base indicating the best approaches to the assessment and management of people with both disorders. This report will summarise this evidence using clinical examples to suggest how psychiatrists can modify their clinical practice to improve care.

While this report is primarily written for psychiatrists and other mental health professionals, improving care for people with CoSUM disorders needs engagement from all relevant stakeholders including local and national commissioners and policy makers. The report makes recommendations for a range of stakeholders and emphasises the critical importance of experts by experience in improving care.

We hope that this report will be valuable in highlighting the needs of one of the most vulnerable groups of people who attend services and by highlighting the evidence, will assist psychiatrists and other mental health practitioners, commissioners and policy makers to make practical and meaningful improvements to clinical care.

Understanding the problem

Clinical challenge

The term co-occurring substance use disorders and mental health disorders (CoSUM) describes a wide range of different co-occurring disorders rather than a single homogeneous entity. People with CoSUM disorders are the most vulnerable group seen by mental health services with the greatest complexity, the highest risk of suicidal acts and violence, and poorest outcomes.

Different CoSUM disorders have different challenges and these disorders are very common presentations across all mental health services, including adult, forensic, child and adolescent, intellectual disabilities, liaison, older adult, eating disorder and other specialist services.

The identification and management of CoSUM disorders not only improves outcomes for people with CoSUM disorders, but also reduces costs to services and suffering for patients and their families. This puts a priority on clinicians having the skills to diagnose and treat CoSUM disorders. Sometimes the treatment of one condition will resolve the other, for example successful treatment of alcohol dependence may resolve low mood and anxiety, but in many cases a more integrated approach is needed. There are significant workforce competence and training needs, both among addiction psychiatrists and general, non-addiction psychiatrists. These training needs will be addressed in this report.

These challenges are happening at a time when substance use and mental health services are under unprecedented pressure. Substance use services, in particular, are experiencing a workforce crisis following a widespread, decade long de-professionalisation of services, including the professions who are particularly equipped to assess, diagnose and treat people with complex presentations. The loss of psychiatrists, psychologists, nursing and pharmacy staff is particularly concerning.

Service models challenge

The recent Dame Carol Black report[1] has highlighted the unmet needs of people with CoSUM disorders and the lack of clarity around commissioning and service models to reduce harm.

Mental health and substance use services are currently siloed with separate commissioning structures with generally poor coordination of care for people who need both services. This has been exacerbated by the commissioning of addictions services outside of NHS structures in England.

Integrated Care Systems (ICSs) in England that pull together a local 'footprint' of health and social care partners have been proposed as mechanisms to help bridge divides such as this, but their effectiveness in practice has yet to be fully realised.[2]

In Northern Ireland, mental health and substance use treatment services are largely commissioned within the NHS but there remain gaps in services.

Scotland has had an integrated NHS structure with unified health boards but local authorities continue to have responsibility for social care.

Wales also has unified local health boards and local authorities continue to have responsibility for social care.

The current service model split of mental health and substance use services has complicated the clinical management of people with CoSUM disorders who despite the existence of ICSs and other structures in the devolved nations, are often excluded from one or both services This exclusion is based on a number of incorrect assumptions. These incorrect assumptions include:

- That people with substance use disorder cannot be treated for co-existing mental health disorders until they have achieved abstinence.
- That mental health services do not have the skills to manage substance use disorders and that substance use services do not have the skills to support people with mental health disorders.
- That neither service has clinical responsibility for the other services' patients due to them lying outside service specifications.

Attempts to coordinate substance use and mental health service providers and commissioners to prevent patient exclusion, such as by taking a 'no wrong door' approach, have often been ineffective.[3] There is no agreed model at scale which a team or service might adopt, and a lack of clear learning from current exemplars of best practice.[4]

Report aims

The aims of this report are to:

- Provide a summary of evidence and best practice for the treatment of those with CoSUM disorders.
- To improve psychiatrists' (and other healthcare professionals') confidence and competence in the clinical management of people experiencing CoSUM disorders.
- Clarify the roles, responsibilities, and competencies that psychiatrists need to support people with CoSUM disorders.

Scope of report

The report will focus solely on people with co-occurring substance use and mental health disorders. Behavioural addictions such as gambling, gaming and compulsive sexual behaviours have been excluded as they are often treated and commissioned outside mainstream services.

Co-occurring physical health conditions or problems (e.g. heroin use and viral hepatitis, alcohol and cognitive dysfunction, ketamine and urological problems) are important

to consider but have been excluded from this report. For information on these topics, please see NHS England's guidance: Improving the physical health of people living with severe mental illness. The report will also not cover alcohol-related brain damage (ARBD).

Tobacco/nicotine use disorders have been excluded from this report as their assessment and management is well documented elsewhere, but it is acknowledged that tobacco smoking is a significant factor in reducing life expectancy for people with severe and enduring mental illness.

Although we acknowledge the important and unique aspects of this area that are relevant with patients with intellectual disability, this is not in the scope of this report.

The report will cover all four nations of the United Kingdom.

Definitions

There are a number of terms widely used in this area including 'comorbidity', 'dual diagnosis' and 'co-occurring disorders'. These terms are variably defined and are sometimes used to describe co-existing physical as well as mental health conditions:

- For the purpose of this report, we will use the term 'co-occurring substance use and mental health disorders' (CoSUM disorders), to describe the population who meet the threshold for the diagnosis of both a mental and a substance use disorder (including alcohol) as defined in the ICD-11.

- Substance use disorders (SUD) – this report will use the World Health Organization's definition that includes alcohol, prescription drugs and illicit substances.[5]

Co-production

'Co-production is a collaborative process and/or relationship that enables individuals from all walks of life to share power in a meaningful way, right from the start'

— World Health Organization

'The term co-production refers to a way of working where service providers and users work together to reach a collective outcome. The approach is value-driven and built on the principle that those who are affected by a service are best placed to help design it.'[6]

— Involve Co-Production

The development of this report has been a collaborative initiative integrating the insights of individuals with personal experiences of addiction and co-occurring conditions, in conjunction with the expertise of specialist addiction psychiatrists and psychiatrists from a range of other specialties where CoSUM presentations are common.

This co-produced document acknowledges and values the expertise of both professionals and those with lived experience, emphasising mutual respect, shared decision-making, and collective accountability throughout the process. It is vital that co-production is not surface- level or "tick-box" but aims for true collaboration and is embedded throughout the process, in an atmosphere of listening, openness, and parity of esteem. Members with personal experience of addiction have been equal members of this working group and through an ongoing process of honest conversation and feedback have played a key role in shaping this final report.

It is paramount that the insights and perspectives of individuals with first-hand experience of addiction are prominently represented. Consequently, we reached a consensus that the report will commence with a foreword emphasising this critical aspect. The authors of this report's foreword have taken the step to share deeply from their personal journeys, and by highlighting the genuine experiences of people with addiction and co-occurring conditions we aim to play some role in breaking down the stigma and unconscious bias which exists at all levels of society, and which deters people from seeking support, hence keeping them trapped in the cycle of addiction.

We hope that the implementation of recommendations given in this report will lead to further destigmatisation alongside the strengthening of available treatment and support.

Principles of clinical care

There are basic principles of care for people experiencing CoSUM disorders, which all psychiatrists should recognised and follow.

The principles below are adapted from the UK clinical guidelines for alcohol treatment: core elements of alcohol treatment:[7]

- **Building a trusting relationship –** a compassionate and humanising approach
- **Reducing stigma** – using non-stigmatising language, not judging or 'othering' people
- **Privacy, dignity, confidentiality and information sharing –** respecting the human dignity of the person, where possible sharing information with consent
- **Access to information** – giving accessible information about the full range of ongoing options for support
- **Shared decision-making and person-centred treatment –** giving people choices and working together with the patient to decide care
- **A strengths-based approach –** focusing on the assets of the person, and supporting them to access peer-based support from the start of treatment
- **Trauma-informed practice –** recognising the impact of trauma and avoiding re-traumatising though ensuring safety, trustworthiness, choice, collaboration, empowerment and cultural consideration. See the working definition of trauma-informed practice.
- **Family and carer involvement** – with consent and as appropriate, whilst recognising not everyone has a family member or carer who can support them. A useful question to ask would be "Is there anyone else you would like to involve?" Understanding a person's social network and how it might add further support.[8]

Principles of service delivery

It is clear from the recent Scottish literature review that the co-occurrence of a mental health condition and problem substance use is related to poor psychological health[9 10] high medical needs[11, 12] sub-optimal levels of engagement in treatment[13] and elevated likelihood of engagement with the criminal justice system.[14] When patients with co-occurring mental health and substance use disorders interact with the healthcare system, they report high levels of unmet needs[15,16] and often cite judgemental attitudes and a skills deficit among providers.[17,18,19]

These issues are important to address from a patient-centred and ethical standpoint. Moreover, patient satisfaction with clinical care is associated with better outcomes.[20] Service-level principles include the following:

Protocols to directly address people with CoSUM disorders

Each local area should have an agreed protocol in relation to the operational interfaces between mental health services and substance use services. This protocol should specify which services are commissioned to deliver what interventions and the pathways available to patients who need support from multiple services.

Further, this protocol should be owned and monitored by a responsible individual or individuals at a senior management level, with clear oversight of both service areas.

Crisis care pathways

A particular concern are local interface protocols between mental health services and substance use services for responding to people with co-occurring disorders presenting in crisis, particularly if they are not admitted to inpatient care. Mental health crisis teams provide full-time coverage whereas substance use services often do not have such coverage. Follow up at a weekend may be necessary in some cases and local protocols should address how this can be realised.

Adequate provision of services for emergency detoxification from alcohol and drugs or emergency stabilisation for drugs (e.g. substitute prescribing) should be available to appropriately care for people presenting with a suicidal and other psychiatric crisis. These presentations often entail admission to general medical or psychiatric inpatient care.

People presenting in acute crisis who are dependent on alcohol or other drugs are highly vulnerable to further deterioration in their symptoms as well as the onset of potentially life-threatening withdrawals. Current provision of medically managed detoxification and/or stabilisation in these settings is often inadequate, despite the knowledge that people may exit care if their withdrawal symptoms are not appropriately managed.[21]

Monitoring access to treatment and outcomes

Routine data collection on care for people with co-occurring mental health and substance use disorders is recommended for both mental health and substance use services. This should include key indicators, such as the number of rejected referrals for people with CoSUM disorders by either mental health or substance use services and what becomes of the referral.

Outcomes of people with CoSUM disorder should be routinely reported and benchmarked by both mental health and substance use services.

Collaboration and sharing best practice

The literature review conducted by the Scottish Government suggests that building formal and informal service integration and networks around co-occurring disorders will be of benefit[22] One way to conceptualise this integration is the idea of a "community of practice".

A community of practice gives practitioners a forum to share knowledge and best practice to develop a more complex understanding of the issues facing people experiencing CoSUM disorders This could prove a cost-effective approach to increasing clinical confidence and competence and the quality of care provided.

Improving the CoSUM competencies of all psychiatrists

All psychiatrists need a sound grounding in addiction psychiatry in order to respond to the needs of the populations they serve. As addiction psychiatry has fewer structural safeguards to maintain trainee numbers than is the case for other specialties, there was a need to establish a requirement (set out in the UK curriculum for psychiatry) for all trainees progressing from Core Training to complete a minimum of two Workplace-Based Assessments (WPBA) of the assessment and management of patients with addiction disorders.[23]

This was approved by RCPsych's Council in January 2020 and was submitted and agreed by the GMC in the following final forms:

1. **The capability in core specific to addictions:** Demonstrate skills in assessing and managing patients with addictions

2. **Combined capability**: Thoroughly assess the general health of your patients, taking into account the impact of their physical health on their psychiatric needs and vice versa. This assessment should include consideration of nutritional, metabolic and endocrine factors, and the physical impact of substance use and addiction

The GMC's new curriculum came into force in August 2022 and a network of 'Regional Addiction Tutors' has been established and supported with quarterly meetings hosted by RCPsych, to ensure that every core trainee has access to a suitably qualified addiction clinician to enable assessment in this essential psychiatric skill.

This requirement has been integrated into the RCPsych curriculum. While significant progress has been made,, it has been to varying degrees in different regions of the four UK nations, with particular variability in English regions. The progress that has been made has mostly been on the basis of goodwill.

It enables all trainees to complete two WPBAs (most commonly Case-Based Discussions) in the management of comorbid substance use or substance use disorders, presenting in any clinical setting (including substance use services [NHS or third sector], acute hospitals, mental health or prison services) and discussed with an 'Addiction Psychiatry Tutor'.

This has been accompanied by an RCPsych webpage of resources: Supporting medical students and trainees in addictions psychiatry

Feedback suggests this is highly valued and much needed structure to improve the competencies of psychiatrists in training to manage patients with CoSUM disorders.

Chapter 2:
A summary of existing evidence

Prevalence of CoSUM disorders

The prevalence of CoSUM disorders is substantial across the UK. The UK Drug strategy reported that up to 70% of people in community substance use treatment also experience a mental disorder.[24] This backs up previous findings which showed that, among patients in community mental health treatment services, 44% reported past-year problem drug use and/or harmful alcohol use, as well as showing that 75% of drug service and 85% of alcohol service patients reported having a past-year psychiatric disorder.[25]

The Dame Carol Black review of drugs highlighted the increasing levels of co-morbidity and complex needs within drug treatment-seeking populations. The report recommended that the Department of Health and Social Care and NHSE develop, publish and implement an action plan to improve the provision of mental health treatment to people with drug and dependence by the end of 2021.[26]

Across the devolved nations of the UK, Scotland has the highest prevalence of opiate, benzodiazepine, stimulant and alcohol use disorders. The concern generated by the resulting levels of CoSUM disorders led to the publication of a suite of reports in late 2022 – one from the Mental Welfare Commission for Scotland and several linked reports from the Scottish Government-that are relevant to this review.[27,28,29]

Impact of CoSUM disorders

The co-occurrence of substance use and mental health disorders is related to poor psychological health,[30, 31] high medical needs,[32, 33] sub-optimal levels of engagement in treatment[34] and increased likelihood of involvement with the criminal justice system.[35] When patients with co-occurring substance use and mental health disorders interact with the healthcare system, they report high levels of unmet needs[36, 37] and often cite judgemental attitudes and a skills deficit among providers.[38, 39]

The difficulty people with CoSUM disorders experience in accessing care is particularly concerning when they need urgent help, such as when a person is experiencing suicidal thinking. In England, 54% of patients treated by mental health services who died by suicide had a history of substance use disorders, but only 11% of those who died between 2012–14 were in contact with substance use treatment services.[40] Across the UK, over half the patients who died by suicide had a history of alcohol or drug use, with alcohol use a more common antecedent of suicide in Scotland and Northern Ireland, drug use more common in Scotland.[41]

Treatment of CoSUM disorders

There are three primary, well-evidenced principles relating to the treatment of co-occurring substance use and mental health (CoSUM) disorders:

- **Person-centred care:**
  Adopting a person-centred approach to reduce stigma and address any inequity of access to services people may face. NICE have emphasised the evidence for how important it is to take a person-centred approach when developing and reviewing the care plan and made a strong recommendation on involving people in their care planning.[42]

- **Everyone's job:**
  Commissioners and providers of mental health and substance use services have a joint duty to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.[43]

- **'No wrong door'** [44]
  Providers in addiction, mental health and other services should have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions should be available through every contact point within the overall mental health and substance use system. The "no wrong door" approach has five major implications for service planning:

  - Assessment, referral, and treatment planning across settings is consistent with a "no wrong door" policy.
  - Creative outreach strategies are available to encourage people to engage in treatment.
  - Programmes and staff can change expectations and programme requirements to engage reluctant and "unmotivated" patients.
  - Treatment plans are based on patients' needs and respond to changes as they progress through stages of treatment.
  - The overall system of care is seamless, providing continuity of care across service systems. This is only possible via established patterns of interagency cooperation or clear willingness to attain that cooperation.

As mentioned earlier, the Scottish Government suggests that the development of a "community of practice" between mental health and substance use services helps to bring about better care for people with CoSUM disorders. In relation to this, the Health Improvement Scotland Pathfinder projects around SU-MH comorbidity in five health board areas in Scotland is welcome.[45]

Given that each individual patient will present with a unique set of overlapping multiple complexities and the very sparse evidence base (in terms of RCTs) that exists for people who present with co-occurring conditions, the aim of person centred care is to base the management plan on care needs (in both immediate and longer term), and have a guiding set of principles upon which to proceed.

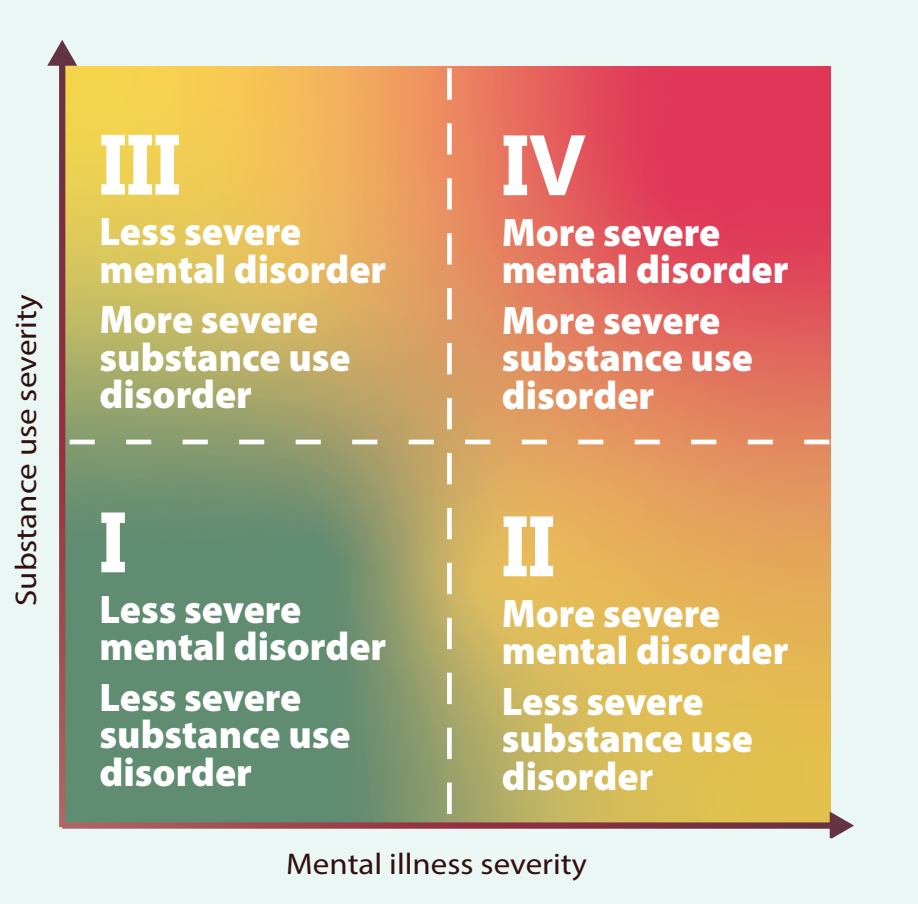
Reviewing the evidence base on both psychosocial and pharmacological treatment, the broad conclusion to be drawn is that an intervention/medication that works for the primary condition will also have some benefit for the comorbid state.[46,47,48,49]

Framing CoSUM disorders by severity

As has already been described, the term CoSUM disorders describes a wide range of different clinical scenarios. Examples include alcohol and anxiety, opioids and depression, cannabis and psychosis, and sedatives and post-traumatic stress disorder. It can be complex for a clinician to conceptualise these varied combinations. One framework, which has been commonly described in the literature, is the so-called severity quadrant model. This divides all CoSUM disorders into four groups.

Quadrant 1 is for presentation with lower severity mental health and substance use. Quadrant 2 is for lower severity mental health but higher severity substance use. Quadrant 3 includes presentations with higher severity mental health but lower severity substance use and the final quadrant, Quandrant 4, is for higher severity mental health and substance use. Clinical presentations are not fixed within a quadrant and may move as symptoms severity changes. The value of this system is to help clinician prioritise treatment need and ensure that pathways to relevant interventions are considered.

Figure 1: Severity quadrant framework



NICE guidelines

The NICE Guideline (2016) on Coexisting severe mental illness and substance use: community health and social care services provides the following guidance on first contact with services:

- Identify and provide support to people with coexisting severe mental illness and substance use. Aim to meet their immediate needs, wherever they present. This includes:
  - Looking out for multiple needs (including physical health problems, homelessness or unstable housing)
  - Remembering the person may find it difficult to access services because they face stigma.
  - Being aware that the person may also have a range of chronic physical health conditions

- Be aware that people's unmet needs may lead them to have a relapse or may affect their physical health. This could include: social isolation, homelessness, poor or lack of stable housing or problems obtaining benefits.

- Be aware that the person may have a range of chronic physical health conditions.

- Provide direct help, or get help from other services, for any urgent physical health, social care, housing or other needs.

- Ensure the safeguarding needs of all people with coexisting severe mental illness and substance use, and their carers and wider family, are met.

- Ensure the person is referred to and followed up within secondary care, and that mental health services take the lead for assessment and care planning.

Chapter 3: Clinical management of CoSUM disorders

What does a non-addiction psychiatrist need to do?

This section is for psychiatrists and other mental health professionals who do not work in, or feel they lack expertise or experience in, substance use disorders.

Understanding psychoactive substances

It is essential that all mental health practitioners understand different types of psychoactive drugs and the psychiatric effects associated with them. This is potentially a huge task given the many hundreds of different drugs available on street and online markets. To simplify this, practitioners can conceptualise psychoactive substances in terms of their psychoactive effect rather than by drug name.

There are three broad psychoactive effects – **stimulant**, **sedative** and **hallucinogenic/dissociative**. This approach allows clinicians to assess signs and symptoms rather than worrying that they don't know what substance has been consumed. This is particularly helpful as often the person using the substance will be unaware of exactly what substance they have consumed, although they are usually very aware of, and are able to describe, the effect. Table 2, below, identifies which common substances fit into each group.

Table 2 – Psychoactive drug effects

Stimulant drugs	Sedative drugs	Hallucinogenic/ dissociative drugs
Common effects: Increased heart rate and blood pressure; agitation; anxiety; restlessness; insomnia; risk of dependence with regular use	**Common effects:** Reduced heart rate; reduced breathing; slurred speech; drowsiness; loss of consciousness; muscle relaxation; incoordination; risk of dependence with regular use	**Common effects:** Hallucinations in any modality; disorganised thinking; agitation; persecutory delusions Dissociation and depersonalisation
Legally available examples: Some ADHD medications, nicotine, caffeine	**Legally available examples:** Alcohol, benzodiazepine medications, gabapentinoids, opioid medications	**No licensed medications with market authorisation in the UK**
Illegal examples: Cocaine; MDMA; methamphetamine; 2CB; piperazines; cathinones	**Illegal examples:** Cannabis, heroin, illegal or diverted medications (opioids, benzodiazepines), GHB	**Illegal examples:** *Hallucinogens:* LSD; psilocybin; tryptamines; DMT *Dissociatives:* Ketamine, methoxetamine

While this simple structure will help practitioners to assess and support people with acute and longer-term substance related presentations and their mental health consequences, it should be noted that some people will use more than one drug at the same time, potentially leading to a mixture of different psychoactive effects. Some drugs also have different psychoactive effects at different doses, for example alcohol is mildly stimulating at low dose but increasingly sedating as the dose escalates. It is also important to be mindful of how the drug has been consumed and its pharmacokinetics.

As a general rule, drugs that have been ingested will have a slower rate to peak effect than those that are taken intravenously, sublingually or snorted. Similarly, the rate at which a drug loses its psychoactive effects also vary. Therefore, it is important to consider if the patient is intoxicated or withdrawing from a particular substance.

Being aware of the different psychoactive effects helps better understand the complexity of CoSUM disorders more generally. Services should avoid treating people with CoSUM disorders as a single group but instead be aware that there are many different co-occurring substance use and mental health combinations and levels of severity, each potentially requiring a different clinical approach. This highlights the need for careful identification/assessment and a clear treatment plan.

To illustrate the diversity of CoSUM disorders, the report has focused on a number of more commonly occurring presentations including:

- Alcohol and depression
- Cannabis and acute/chronic mental health presentations
- Stimulants and psychosis
- Drug use and post-traumatic stress disorder
- Opioids and acute/chronic mental health presentations

Patterns of substance use

When assessing someone who uses substances, it is critical to understand the pattern of use and how this relates to co-occurring mental health disoders. Substance use can be broadly divided into these groups as follows

Occasional use

This includes people who use occasionally. This could include episodes of heavy use leading to intoxication (a transient condition due to recent substance use resulting in behavioural, cognitive, and physiological change).

Harmful use

A pattern of substance use causing physical or mental health problems without the presence of dependence.

Dependent use

A syndrome characterised by priority given to substance use over other obligations, strong cravings, tolerance, and withdrawal symptoms (Symptoms that occur upon cessation or reduction in substance use after prolonged, heavy use).

Understanding the pattern of use is essential as it will determine the most appropriate treatment plan. An example is whether medically assisted detoxification is required. Screening tools, such as the ASSIST-lite, when combined with careful history-taking and physical assessment, can help in assessing the pattern of use.

Identification and assessment of substance use disorders (screening tools)

Aligned with national guidance[50] it is recommended that mental health services utilize the ASSIST-lite tool alongside clinical assessment to detect substance use disorders.[51]

The ASSIST-lite tool has a number of advantages including covering all major psychoactive substances (including alcohol) and being included within the Mental Health Service Dataset (MHSDS) in England.[52]

All psychiatrists should be able to use the ASSIST-lite across a range of settings to identify if problematic substance use is present.

The UK Government provides guidance on how to use the ASSIST-lite.

Brief interventions for substance use disorders

Brief interventions are lower intensity psychosocial interventions which can easily be delivered by a mental health practitioner without expertise in substance use treatment.

They are often opportunistic interventions delivered outside of substance use services, when a substance use disorder is identified. As such, all mental health practitioners should have skills in offering brief interventions, which often take only a few minutes and are typically part of a broader conversation about a person's health. These should be integrated into the overall assessment and treatment plan.

Brief interventions are recommended by NICE and one of the simplest structures is known as FRAMES (see Box 1). This is an NHS approach taught on Elearning for Healthcare (ELFH).[53, 54]

Liaison, signposting and referral to other services

It is important to make sure that mental health services have a menu of options for people experiencing CoSUM disorders, alongside an understanding of which option is likely to be most appropriate for their patient. Substance use options could include: easily available information for patients to raise awareness of the interplay between substance use and mental health disorders, referral to local substance use services, referral to peer led options (such as Alcoholics Anonymous) or other locally provided services.

Though it is important to ensure there is a clear referral pathway to specialist substance use treatment, mental health staff should ensure substance-related problems and plans for their management are described in care plans. It is insufficient to simply

state the patient has been referred to substance use services. Instead, attempts should be made to liaise and coordinate treatment, such as holding a professionals meeting or utilising a community of practice approach.

This approach is likely to significantly improve outcomes for the patient and reduce the risk of poorly coordinated treatment leading to relapse of mental health disorder, substance use disorder or both.

Exclusion of people with CoSUM disorders from services is commonly reported by both patient and services themselves. These barriers should be directly challenged as part of advocating for the patient. The offer of joint working, or the request for an assessment followed by a discussion is often sufficient to break down these barriers. Where it is not, the case should be escalated and the clinical leads of both services and, if necessary, the service commissioners should agree a resolution in the best interests of the patient.

Box 1: FRAMES model for brief interventions in substance use problems

Once a substance use problem has been identified, engage the person in the following conversation structure:

FRAMES model:		
F	**(Feedback)**	Provide feedback on person's current and likely substance-related risk
R	**(Responsibility and choice)**	Emphasise the person's responsibility for and choice in making any change
A	**(Advice to change)**	Give clear advice to change substance use
M	**(Menu of options)**	Offer a variety of strategies or options to reduce the risk of harm and engage in further support
E	**(Empathy)**	Use a warm, reflective and understanding style of delivery
S	**(Self-efficacy and optimism)**	Build confidence that change is possible

Treatment

Treatment plans should be developed based on a person's needs, acknowledging that these may change.

Joint working between mental health and substance use services will be essential to support and treat people with more severe CoSUM disorders. Joint working will be determined by local systems, but examples include:

- joint working protocols
- joint multi-disciplinary team meetings
- community of practice
- co-located clinics
- ad-hoc professionals' meetings
- shared learning/training sessions
- consider involving people with lived experience in treatment systems
- ensuring systems are in place to monitor access and outcomes. This will likely involve discussion of data sharing between services.

Trauma-informed practice

Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.

Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

It also aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in partnership with people using services, empowering them to make choices about their health and wellbeing.

Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask "What does this person need?" rather than "What is wrong with this person?"

The purpose of trauma-informed practice is not to treat trauma-related difficulties, which is the role of trauma-specialist services and practitioners. Instead, it seeks to address the barriers that people affected by trauma can experience when accessing health and care services.

According to the Office for Health Improvement and Disparities, there are 6 principles of trauma-informed practice: safety, trust, choice, collaboration, empowerment and cultural consideration.[55] This approach is particularly important for people experiencing CoSUM disorders, as substance use problems can develop as a maladaptive coping mechanism for trauma.

Monitoring

One of the challenges of improving services for people experiencing CoSUM disorders is the gaps in knowledge about the extent of the problem and the effectiveness of current pathways. Much evidence suggests that these pathways are failing people, but systems to accurately measure progress are poorly utilised. This emphasises the need to improve the accuracy with which CoSUM disorders are identified, outcomes measured and these data made available for service planning. Use of the ASSIST-lite should improve this and allow for auditing.

What does an addiction psychiatrist need to do?

This section is written for addiction psychiatrists and other professional groups working in specialist substance use services.

There will be a substance use service commissioned in every borough/county of the UK. These may be under the NHS, Health and Social Care in Northern Ireland, third sector or a partnership between a number of services. In some areas, there may be the option of having GP-shared care clinics within the GP practice.

Identification and assessment of mental health disorders

In the same way that general psychiatrists need to identify and assess substance use disorders in people with mental health disorders, addiction psychiatrists need the skills to identify mental health disorders in people with substance use disorders. A clinical challenge will be disentangling substance-induced symptoms from those of co-occurring mental health conditions. Careful history-taking will be essential, including examining the relationship between substance use and mental health symptoms and changes in symptoms severity during periods of abstinence from substances. The use of screening tools such as the PHQ-9 and GAD-7 may support this, as well as provide a mechanism to track progress in treatment.

Brief interventions for mental health disorders

Brief interventions are lower-intensity mental health interventions which can easily be delivered by substance use services and include assessment, advice and signposting for common mental health illnesses in line with the 'no wrong door' approach. Assertive linkage to appropriate mental healthcare should be considered a core role for substance use services and joint working is to be encouraged. Involvement of primary care is recommended. Many substance use services employ psychiatrists and other senior mental health practitioners. This is to be encouraged as it is likely to substantially improve the care of people with co-occurring substance use and mental health disorders.

Management of severe and enduring mental health conditions remains the remit of statutory mental health services who are commissioned and funded to provide this specialist care.

Liaison, signposting and referral to other services

The severity and type of co-occurring mental health disorder will determine the most appropriate service. If someone is experiencing first-episode or persisting psychotic symptoms, severe affective symptoms or other severe mental health symptoms (e.g. low-weight anorexia nervosa, severe post-traumatic stress disorder), this suggests the need for referral to a specialist mental health service.

Treatment

Addiction psychiatrists and the teams they work in should, however, be competent in managing mild to moderate symptoms of co-occurring mental health disorders such as anxiety and depression. The confidence and competence of substance use services to initiate treatment for mild to moderate disorders will vary from team to team and psychiatrist to psychiatrist. It would, however, seem reasonable for an addiction psychiatrist within a substance use team to deliver mental health treatments at the level of, or above, that of a general practitioner.

The de-professionalisation of substance use services, particularly in England, over the last decade has seen a significant decline in the number of psychiatrists (and psychologists and specialist nurses) working in substance use services, and a decline in the availability of addiction higher training places (in England).[50.] Commissioners should be aware that services without these expert resources are unlikely to meet the needs of people experiencing CoSUM disorders, who form a very significant proportion of people attending the services.

Monitoring

Substance use services have clear systems of data collection and monitoring. In England, this is the National Drug Treatment Monitoring System. It is a priority for substance use services to accurately record information on people presenting with CoSUM disorders to build an accurate picture of the prevalence and levels of severity. Regular audits of referrals to other services (including accepted and rejected referrals) is also critical.

Chapter 4:
Clinical cases and their management

The following section will focus on the clinical management of commonly presenting CoSUM disorders and will include

- alcohol and depression,
- cannabis and acute/chronic mental health disorders,
- methamphetamine and psychotic disorders,
- sedatives and post-traumatic stress disorder
- opioids and mental health disorders

There will be a further discussion of vulnerable populations including women in the perinatal period, homelessness and neurodivergence.

For all these cases, basic harm reduction/minimisation applies to be provided to all patients.

Box 2: Harm reduction advice:

- Try not to use drugs on your own and tell someone else what you have taken
- Use clean needles and don't share other drug paraphernalia (e.g. foils and crack pipes)
- If someone you are using with is asleep, put them into the recovery position
- Avoid mixing drug types
- Use a small amount at a time and wait to assess the impact before re-dosing
- Be wary of buying from new dealers or using in new environments

Alcohol and depression

Key facts

What is the drug and how does it work?

- Ethanol is a compound with a rich pharmacology, with specific targets across a wide range of receptors including NMDA, GABA-A, and 5-HT3.[56]
- NMDA inhibition and facilitation of GABA-A transmission appear important for the characteristic pharmacological effects including intoxication, dependence and withdrawal.

Prevalence rates

The most recent large survey of the UK population[57] showed:

- 79% drank alcohol in the last year, 49% drank at least once a week [58], 11% drank on 5 or more days a week.
- Alcohol consumption and harm increases with age, peaking at 55-64 before declining.
- The COVID-19 pandemic resulted in lower-risk drinkers drinking less while heavy drinkers drank more,[59] and these patterns have continued.[60]
- Alcohol-specific deaths in the UK are now at the highest level on record, having risen sharply after the pandemic.[61]

Short-term harms

Acute alcohol intoxication is associated with harms including injury, suicidal thinking and acts, violent crime (as victim and perpetrator) as well as potentially fatal harms due to respiratory illness, depression, aspiration, Mallory-Weiss tears causing haematemesis and acute pancreatitis.

Long-term harms

Drinking at higher levels for prolonged periods is associated with multiple health harms, which may either be a direct effect of alcohol or secondary (e.g. neglect of other health conditions or responsibilities) including:

- **Psychiatric:** Increased risk of depression, anxiety, self-harm and suicide, and is associated with longer time to recovery from, and risk associated with, bipolar disorder.

- **Physical:** Hypertension, liver cirrhosis, cancer, cardiac arrhythmias and haemorrhagic stroke.

- **Social and economic:** This includes loss of productivity, job loss, road traffic accidents, violence and relationship breakdown, domestic violence and housing security.

Alcohol case study

Patient case

Alex is a divorced 45-year-old man, living on his own in private rented accommodation, who attends the emergency department terrified by urges to hang himself. At presentation, Alex is clinically intoxicated with alcohol, slurring and ataxic. He reports drinking a bottle and a half of wine that evening in an attempt to feel better. He denies any other drug use and describes feeling profoundly hopeless.

On further questioning Alex describes several weeks of low mood following a very stressful period at work, including being put on a performance improvement plan. He is also struggling to keep up with rental payments.

Alex has a history of depression, which has been treated by his GP with sertraline to no benefit, but there is no previous history of suicidal thinking or self-harm. His drinking has crept up over the last 12 months, which he says in response to stress and feeling lonely.

Considerations on initial presentation

The immediate priority in the case of someone who is intoxicated, in high distress and expressing suicidal thinking is their safety, and the initial management plan should reflect this.

Suicidal ideation may resolve with time and resolution of intoxication or could instead be revealed once sober to be part of an ongoing depressive episode.

Characterising the pattern of alcohol use is critical to developing a clinical management plan. Is this presentation a rare episode of intoxication, part of escalating harmful use or an existing dependence syndrome? If alcohol dependent, potentially life- threatening withdrawal symptoms may develop as the patient becomes sober. The patient should be asked specifically about any previous experience of withdrawal symptoms including seizures and delirium tremens.

What is the relationship between his use of alcohol and his mood? Alcohol dependence and depression can be bidirectional with each conferring worse prognosis on the other. Do not assume that intoxication explains the presentation.

Initial considerations:

- Is the patient alcohol dependent and if so, is a medically assisted detoxification needed?
- If a medically assisted detoxification is needed, what is the local pathway? Most substance use services do not offer emergency detoxification, although there are examples where Home Treatment Teams (HTT) and community substance use services work jointly to provide detoxification and crisis care concurrently.[62]
- Does the patient describe symptoms which meet the diagnostic criteria for depression or other psychiatric diagnoses?
- Has the patient been in a similar situation in the past? If so, what helped?
- Assess for use of other psychoactive substances, such as cocaine. Consider a urinary drug screen in addition to thorough history of all substance use
- What support does he have from family, friends, professionals? Who could support him today?
- Do not exclude the patient from crisis pathways on the basis that he is intoxicated with alcohol or is dependent on alcohol.

Initial considerations (continued:)

- It is important to re-assess the patient once sober as his clinical presentation may have changed significantly. How can the patient be kept safe while the effect of alcohol wears off?
- Use local risk management tools and pathways once the patient has undergone a further assessment when sober.
- Always ask about childcare responsibilities.
- Is the patient currently driving?

Longer-term considerations

Suicidal crisis may be precipitated by a combination of alcohol use disorder, other psychiatric disorder and social stressors. The relative contribution and severity of each will lead to an emphasis of different aspects of the care plan.[63]

Patients with harmful, hazardous or dependent use of alcohol in suicidal crisis do not have worse outcomes than suicidal patients without this if treated by the HTT[64] so should not be excluded from this pathway.

If alcohol dependent, then what is his goal? This could be abstinence, controlled drinking (if possible) or not yet wanting any treatment.

Some patients who are alcohol dependent will choose not to access abstinence-based pathways including refusal of a medically assisted detoxification. This should not be seen as a failure on the part of the patient, as there are many factors complicating the decision to identify abstinence as a treatment goal. For patients not wanting an abstinence pathway there is still much that can be done starting with provision of harm reduction information, such as consumption diaries, advice on safe limits, signposting to treatment services and other community supports and follow-up to assess further needs.

Service structures and how they should function

Differences in commissioning across the four nations have led to different approaches to the clinical management of people with CoSUM disorders. Guidance encourages an approach characterised by 'no wrong door' and 'everybody's job'.

In crisis pathways and for more routine care, the following can be treated as a checklist for services:

1. Avoid assuming that signs and symptoms are due to alcohol until a full assessment can be conducted.

2. Do not exclude people presenting with intoxication from making decisions about their care because they are intoxicated.

3. Does your service have a clinical pathway for people who present intoxicated (and possibly also suicidal) who need medically assisted detoxification as part of the risk management plan?

4 Ensure that people with Alcohol Use Disorder (AUD) are not explicitly excluded from services, pathways and interventions for management of mood disorders, suicidality/self-harm and other psychiatric disorders? For example, psychosocial interventions, HTT or CMHT.

5 What follow up protocols are in place for people with AUD presenting with psychiatric crisis? For example, delivery of brief intervention, offer of follow-up, assertive referral to local alcohol service.

Key learning

Assessment and treatment

- Alcohol screening tools are recommended for all health professionals in outpatient, inpatient or Emergency settings to assess a person's level of alcohol risk.[65]
- The Alcohol Use Disorders Identification test (AUDIT) is widely used in England in healthcare settings and it is recommended that all clinical staff involved in the care of people who may be experiencing AUD are trained to use this tool or alternatively use ASSIST-lite tool.
- Inpatient units should use a validated withdrawal scale and ensure staff are trained in its use to monitor alcohol withdrawal and facilitate symptom triggered treatment.
- Breath Alcohol Concentration (BAC) can provide useful information in addition to clinical assessment but should not on its own be used to guide decisions about clinical care.
- BAC should only be used to guide when it is safe to initiate medically assisted detoxification, when used in conjunction with a withdrawal symptom rating scale (e.g. CIWA or GMAWs), as people with severe alcohol dependence may experience withdrawal symptoms (including withdrawal seizures) before their BAC has reached zero.
- Soft skills of clinicians are important (both whilst the patient is intoxicated and once sober), providing a kind approach, and giving hope to help reduce the sense of loneliness and shame often described by people with CoSUM disorders.

Treatment decisions

- For people with alcohol dependence and a depressive disorder at presentation, discuss with the patient whether they would consider undertaking a medically assisted detoxification from alcohol. Some patients will experience a resolution of their depressive symptoms in the 2-3 weeks post abstinence, suggesting that alcohol was the likely cause of these symptoms. (50% pre-abstinence meet criteria for clinical depression vs 10-30% once abstinent).[66]
- If depressive symptoms persist once the patient is no longer intoxicated, then apply standard clinical pathways for depression management, as depression can significantly impair engagement in substance use treatment.
- Patients may need concrete support to facilitate engagement with both mental health and substance use services, e.g. their CPN escorting them to an substance

use service for an assessment and their need for this support should not be interpreted as a demonstration of insufficient motivation to change.

- Considerations in prescribing and monitoring antidepressant medication include liver function, and in patients with advanced liver disease, risk of hyponatraemia and risk of encephalopathy.

Self-help and online resources

- SMART Recovery
- Alcoholics Anonymous
- RCPsych guidance on alcohol
- NHS Alcohol Identification and Brief Advice

Cannabis and acute/chronic mental health presentations

Key facts

What is the drug and how does it work?

- Cannabis is a plant-based drug that traditionally refers to the dried flowers, leaves, stems, and seeds from the Cannabis sativa or Cannabis indica plant.
- The plant contains many psychoactive compounds, but THC (delta-9-tetrahydro-cannabinol) is the most important.
- The plant also contains other compounds including cannabidiol (CBD), which is psychoactive but is not intoxicating in typically consumed amounts.
- The potency of cannabis is generally assessed by considering the THC content which typically ranges from 5-20%, although it can sometimes be far higher than this.[67] Higher strength cannabis products are often termed 'skunk'.
- Cannabis is available on illegal markets as dried flower and leaves, and as plant resin, which are usually smoked. More recently the illegal cannabis market has diversified to include edible and topical products, as well as oils which can be vaped.
- Synthetic cannabinoids are also available on illegal drug markets. These substances attempt to mimic the effects of plant-based cannabis, by working directly on the cannabinoid system, but contain no THC and CBD. Synthetic cannabinoid products are usually more potent and toxic than plant-based cannabis.
- In the UK, cannabis is an illegal drug, falling under Class B of the Misuse of Drugs Act. There are a small number of legal medications containing THC and CBD which are licensed for specific indications.

Prevalence rates

- Cannabis is the most used illicit substance in the UK, with 7.6% of adults between 16- to 59-years-old reporting having used the drug within the past year and 15.4% of those aged between 16 to 24 years old.[68]
- Around a third of people who use cannabis develop a problem with the drug (i.e. a cannabis-use disorder) at some point during their lives. This is a similar proportion to other substances: alcohol (38%), sedatives (39%), opioids (47%) and stimulants (50%)[69]. Despite this, the majority of cannabis users do not believe that cannabis is addictive[70] or poses significant risk to health.

The ways it is used

Common methods of ingestion include:

- **Smoked:**
  Cigarette (with or without tobacco) or through a pipe or water tank – 'bong'.
- **Inhaled:**
  Vaping/electronic cigarettes.
- **Sub-lingual:**
  Oils, which are usually placed on the tongue using a dropper.
- **Ingested:**
  Cakes, brownies, yoghurt, gummy sweets, solutions and a range of beverages.
- **Topical:**
  Lotions and creams.

Short-term harms

Acute intoxication: Effects typically last 2–4 hours and include euphoria, intensification of sensory experiences, motor impairment, uncontrolled laughing, perceptual distortions, hallucinations, anxiety and persecutory thinking and delusions. Physical symptoms of intoxication include tachycardia, postural hypotension, increased appetite, irritated or red conjunctiva and dry mouth.[71]

There have been occasional case reports of serious consequences, such as cerebrovascular events.[72, 73]

Long-term harms

- There is a complex and bi-directional relationship between cannabis and psychotic disorders. Cannabis may be a contributory factor in developing psychotic illness.[74.]
- The risks appear to be much greater in adolescents,[75] and in heavy/daily users.[76]
- Cannabis-induced psychosis has a higher risk of transition to a schizophrenia spectrum disorder (36%); compared to other substance-induced psychosis- alcohol- (13%), opioid- (17%), and amphetamine-induced psychosis (25%).[77]
- Cannabis use disorder is common in patients with first episode psychosis (36%) and schizophrenia (22%).[78]
- In first-episode psychosis, stopping heavy cannabis use halves the risk of psychosis relapse at 2 years (24% vs. 58%).[79]
- Daily cannabis use is associated with increased odds of psychotic disorder compared with never users, increasing to nearly five-times increased odds for daily use of high-potency types of cannabis.[80]
- Some research shows that cannabis causes less dependence than other substances. However as significantly more people use cannabis worldwide compared to other drugs, the population prevalence of dependence is higher. Some studies have quoted figures of 9% of those using cannabis go onto develop dependence compared to 15% of those who try cocaine or 24% of those who try heroin.[81] Most people with cannabis dependence use 0.5 – 3.5 grams of high-potency cannabis per day.

- Cannabis use disorder is associated with an increased risk of developing respiratory conditions such as chronic obstructive pulmonary disorder (COPD).[82]
- There are established links between long term cannabis use and depression, anxiety, amotivational syndrome (characterised by reduced desire to work or compete, passivity, and lower achievement orientation).[83]
- Social impacts can include isolation, demotivation and the effect on wider family and community, particularly for people who use larger amounts. Additionally, there is evidence that frequent cannabis use is a potential risk factor for violence and aggression.[84,85]

Medicinal cannabis

In the UK, NICE guidelines recommend Cannabis-based products for medicinal use (CBPMs) for intractable nausea and vomiting (usually linked to chemotherapy), spasticity in multiple sclerosis, and rare forms of childhood epilepsy.[86] There are no other licensed indications, but the value of CBPMs in other conditions such as chronic pain, anxiety and addiction are being explored. Please see RCPsych's position statement on cannabis-based medicinal products for more information.

Cannabis case study

Patient case

Alan is a 24-year-old man brought to A&E by police, after being found distressed and crying uncontrollably in the street. He reports a two-week history of feeling paranoid about his neighbours and is increasingly worried about the safety of his family and friends. He says he doesn't feel safe, resulting in him avoiding returning home for the last two days and he has been sleeping in various hiding spots on the streets and in a local park. He is frightened, agitated and responding excessively to sounds around him. Alan describes over the last few months hearing 'threatening voices' of people he knows.

On further assessment, Alan reports that he began using cannabis "for fun with friends" when he was 13 years old, but at the time only smoked once a week. When he started college aged 18 years old, his cannabis use increased substantially and for the last two years has been smoking about £10 a day. Alan describes cannabis as assisting with sleep and also "quietening the voices".

Considerations on initial presentation

Base clinical decisions (e.g. admission) on clinical need and safety, irrespective of whether the symptoms are thought to be due to substances or other mental health disorders.

People who use alcohol and illegal drugs may experience significant stigma at being labelled a 'drug user' and have concerns about how this may affect the treatment they receive.

Cannabis withdrawal syndrome usually starts within 24-48 hours of cessation and normally peaks after 2-6 days and can present with insomnia, vivid dreams, irritability, anger, anxiety, low mood, cravings, restlessness, appetite changes, headache, tremor and sweating. Most regular cannabis users report symptoms of cannabis withdrawal, and about half of heavy users describe them as being 'severe'.[87, 88]

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Considerations on initial presentation (continued)

Some people can stop using cannabis abruptly without significant discomfort, but others have to slowly reduce their use over several weeks or months. Treatment guidelines have suggested using promethazine, benzodiazepines, hyoscine, metoclopramide, and paracetamol for symptomatic relief.[89] There are currently no UK guidelines available or medications currently approved specifically for medically assisted withdrawal. If, on admission, people are noted to be experiencing the above mentioned withdrawal effects, which are causing severe distress, use medications supportive for symptomatic management in the short term, e.g. hypnotics for insomnia, anti-nausea medication and low-dose short-term benzodiazepines. It may be worth contacting local drug services and pharmacy for support and advice.

Cannabis intoxication usually lasts 2-4 hours, but may be longer after oral administration or with high doses.

Assess frequency of use including days per month and consumption per day or week (usually described in grams by people who use cannabis). Consider using an assessment tool such as Cannabis Use Disorder Identification Test (CUDIT) or ASSIST-lite.

Consider Urine Drug Screen (UDS) in A&E or, if not possible, on the ward. Test for cannabis but also for other drugs which may have been co-ingested and may be contributing to the clinical presentation. THC has a long terminal elimination half-life, so heavy users may test positive even if they have not consumed cannabis for days or even weeks.[90]

Consider co-addictions, especially tobacco.[91] Be aware of rise in synthetic cannabinoids (SC) and their particular health risks (esp. cardiotoxicity).[92] Use of synthetic cannabis may be higher in certain cohorts such as homeless/prison population.

Consider whether the patient is currently driving.

Longer-term considerations

Use of cannabis does not equate to dependence. It is important to undertake a clear clinical history to establish use and any evidence of dependence. There are cannabis-specific screening tools if clinicians wish to use them e.g. CUDIT – Cannabis Use Disorder Identification Test. The use of screening tools should always be combined with clinical assessment when determining dependence.

Consider prognosis: if symptoms (such as psychosis and mood disturbance) appear to be cannabis induced, these symptoms may be transient and resolve with abstinence over a short period. Equally, the symptoms may relate to a longer standing schizophreniform illness.

Do not assume causality between symptoms and drug use and discharge people with a diagnosis of “drug induced psychosis” and no further follow up. Safety considerations should inform decision-making, so consider each case individually to decide which services will be most useful to provide ongoing support, for example the CMHT, crisis team and/or substance use services.

Psychoeducation is important: supporting a person to develop understanding of how cannabis may be affecting their mental state is key. Try to be curious with them about what, how and why they use, and what the effects are. Provide information, for example the symptoms of cannabis withdrawal syndrome, and tools, such as a cannabis/drug consumption diary.

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Longer-term considerations (continued)

Consider societal and group norms; the use of cannabis will be normalised in some settings and the person and their peers may not even consider it to be a drug in the way they do other psychoactive substances. The increasing awareness surrounding medicinal cannabis can lead to a misunderstanding that all cannabis use is therapeutic.

Promote harm reduction to everyone and offer treatment if indicated – limiting amount/time of day used; using less cannabis in each joint, using less strong forms (e.g. not skunk); using cannabis to relieve withdrawal symptoms rather than achieve intoxication, avoiding mixing with other drugs/alcohol.

63% of people with first episode psychosis and co-occurring CUD have a further relapse with high rates of hospitalisation. Observational research suggests that antipsychotic treatment is associated with a reduction in risk, with the greatest reduction in risk associated with clozapine and long-acting injectables.[93]

Service structures and how they should function:

Encourage the person to attend the local drug service – find out what services they have specifically for people who use cannabis. Your patient may be reluctant to attend, especially if they don't see their cannabis use as problematic, in which case ask them to test their control by seeing if they can manage a period of self-imposed reduced use. This may help them make a judgement about whether their use is a problem or not.

Work around the cannabis use should not be seen as solely the remit of the drug service; useful interventions such as motivational interviewing, psychoeducation, and harm reduction can and should equally well be undertaken at the CMHT.

Consider joint working - key working and care coordination between drug and mental health teams.

Key learning

As a clinician working with cannabis users, you should:

- Have knowledge of cannabis potency, typical use patterns, and the symptoms of intoxication and withdrawal
- Understand that cannabis sometimes provides short-term relief for affective and psychotic symptoms, even if it is counterproductive over the long-term
- Promote harm reduction as well as abstinence depending on the person's goals.
- Be able to offer psychoeducation, motivational interviewing and medical interventions
- Understand that you should support and train clinicians working in community mental health teams as well as drug and alcohol services to offer these interventions

Self-help and online resources

- Marijuana Anonymous
- Safer Use Limits (Cannabis)
- RCPsych guidance (Cannabis and mental health)

Methamphetamine and psychotic disorders

Key facts: Stimulants

What are the drugs and how do they work?

- All stimulant drugs increase synaptic availability of dopamine and noradrenaline, either by causing its release or inhibiting re-uptake.
- Methamphetamine is more readily absorbed into the brain and its effects last longer than amphetamines or cocaine, with a half-life of 6-12 hours.[94]
- It is typically a white crystalline substance and is smoked, snorted, injected intravenously ('slamming') or inserted anally ('booty bumped').[95]
- Street names include 'crystal meth', 'Tina' and 'ice'.[96]
- Desired effects include euphoria, increased energy, alertness, decreased appetite, increased libido, reduced inhibitions and delayed ejaculation.
- In the UK, methamphetamine is sometimes used to facilitate sexual performance, particularly in men who have sex with men.
- *Sensitisation,* which is greater dopamine release in response to repeated challenges with amphetamines, has been demonstrated in humans[97] – the behavioural correlate in preclinical studies is increased psychomotor agitation – it is of relevance to development of methamphetamine psychosis – see below.

Short-term harms

Unwanted short-term effects include:

- Fear
- Irritability
- Agitation
- Severe insomnia
- Disinhibition
- Repetitive activities
- Persecutory delusion
- Hallucinosis
- Dehydration
- Rhabdomyolysis +/- acute kidney injury
- Cardiac arrhythmia
- Aortic dissection
- Stroke
- Hyperthermia
- Serotonin syndrome
- Sexual risk taking
- Violence

Unwanted effects commonly outlast the euphoria.

Long-term harms

- It is thought around half of people using methamphetamine meet the criteria for methamphetamine use disorder.[98]
- In those who are dependent, acute methamphetamine withdrawal syndrome is common on cessation or reduction. Symptoms include intense drug craving, severe dysphoria, emotional lability, anxiety, restless legs, hypersomnia, persecutory thinking and suicidality. The syndrome can persist for weeks or even months after last use.

- There is a dose-related increase in violent behaviour during periods of methamphetamine use that is largely independent of the violence risk associated with psychotic symptoms.[99]
- Blood-borne virus infection
- Pulmonary complications: pulmonary oedema, granuloma, pulmonary hypertension
- Skin picking lesions and soft tissue infections
- Poor oral health
- Depression, anxiety, psychosis

Methamphetamine psychosis

- Psychotic symptoms typically occur within 48 hours of methamphetamine use and are associated with symptoms indistinguishable from acute schizophrenia. Methamphetamine intoxication is not an exclusion criterion.[100]

- There appears to be a dose-dependent relationship between frequency of use and risk of experiencing psychotic symptoms.[101]

- Psychotic symptoms associated with methamphetamine use exhibit *sensitisation* – a shift from non-psychotic to pre-psychotic states e.g. delusional mood and ideas of reference, to more florid psychotic symptoms[102] – so it is important for patients with pre-psychotic or mild/self-limiting psychotic symptoms to know that the risk of psychosis increases with repeated use.

- Recent consensus guidelines distinguish between acute methamphetamine-induced psychosis and persistent forms which can be subacute (<1 month since last use) or chronic (> 1 month since last use). It is important for clinicians to be aware that not all methamphetamine related psychosis is brief and time limited and prognosis is variable.[103]

- Between 20% and 30% of stimulant-related psychosis is later reclassified as schizophrenia.[104]

Methamphetamine case study

Patient case

A 38-year-old man, Martin, is brought in to ED via ambulance on a Sunday evening. An ambulance was called by neighbours who reported that they could hear crashing noises in his flat and that he sounded distressed. This was out of character for Martin. When the ambulance crew entered Martin's flat, they found that he had smashed all his computers and his phone and he wasn't making sense when spoken to.

Martin agreed to accompany the ambulance team for an assessment to hospital and the team noted that Martin had previously been in hospital with chest pain following smoking methamphetamine. On arriving at the ED, he had no chest pain but was hypertensive, tachycardic, agitated, hostile and seemed preoccupied by what clinicians in the central computer area of ED were looking at. He was also preoccupied by staff ID badges and he repeatedly asked people to confirm their role at the hospital.

There was evidence of tangential thinking, loosening of associations, ideas of reference and considerable paranoia. Martin reported that he was being monitored through his computer as part of a broader conspiracy designed to "shame me".

Martin described the conspiracy starting 48 hours previously during a chemsex party, when people started to speak about him "in code".

He shows WhatsApp messages, which to your mind could be interpreted in various ways, but are not obviously threatening. He reports delusional perception, believing that the noise from the air conditioning signals the release of Rohypnol into the department.

Considerations on initial presentation

- Ensuring patient safety is a key priority. This is particularly important given the patient's agitation and persecutory thinking. Consider moving to low-stimulus environment and the need for security staff to ensure patient and staff safety.
- A medical review to assess for dehydration, tachycardia, arrythmias and neurological complications.
- Review any available collateral information, including previous psychiatric presentations/diagnoses.
- Urinary drug screen to confirm presence of methamphetamine and also to check for other substances (e.g. benzodiazepine use which, if dependent, can cause withdrawals if stopped abruptly). Check for evidence of alcohol use e.g. blood alcohol level via breathalyser.
- Always ask people who use methamphetamine if they also consume GHB (a highly addictive industrial solvent commonly co-ingested with methamphetamine, particularly by men who have sex with men). If the patient uses GHB it is essential to establish whether they are using GHB dependently, GHB withdrawal symptoms are potentially life threatening and include delirium. Management of GHB withdrawals often requires high-dose benzodiazepine treatment in an acute medical setting and sometimes the addition of baclofen.[105] If the patient is unable to give a history because of thought disorder for example, and there is no collateral, a period of monitoring for GHB withdrawal using the CIWA withdrawal screening tool is indicated.
- Suggested bloods including liver and renal function and creatinine kinase to assess the risk of rhabdomyolysis and Acute Tubular Necrosis.
- Assess for other causes of presentation including mental health (schizophrenia, bipolar affective disorder, psychotic depression) or physical (head injury, post-epileptic state, metabolic dysfunction)

(list continues on the next page)

Considerations on initial presentation (continued)

- There is no antidote or substitute prescribing for methamphetamine. Instead, consider benzodiazepines to manage agitation and facilitate sleep.
- If rapid tranquilisation is indicated, first use benzodiazepines and if an antipsychotic is required use one with low propensity to cause extra-pyramidal side effect (EPSE) as stimulant use confers a fourfold increase in risk of EPSE.
- Avoid use of cuffs or manual restraint.
- Urgent review by mental health team including a capacity assessment and consider use of Mental Health Act as indicated.
- Is the patient currently driving?

Longer-term considerations

- Determine need for onward psychiatric care. As the effects of methamphetamine intoxication resolve, reassessment of psychotic symptoms is essential as symptoms can resolve completely, persist in obvious clinical form, or remain present but change in their expression as the patient becomes less distressed and disinhibited.
- When the patient is well enough to engage, discuss options including referral to substance use and mental health care with a pathway to coordinate care across both services.
- Provide harm reduction information about methamphetamine and other substances as indicated.
- Discuss sexual health including screening. Consider pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) as appropriate

Service structures and how they should function

- Minimise use of manual or physical (meaning non-people) restraints.
- Ensure training in cultural competence and awareness of the possibility of persistent methamphetamine-induced psychosis developing in a significant minority of patients.
- Ensure all staff are competent and confident to deliver harm reduction and brief interventions.
- Involve patients in reviewing and co-developing protocols for management of methamphetamine psychosis.
- Develop specific pathways involving ED, substance use services, mental health services (including crisis care) and sexual health services to allow complex needs to be addressed.

Self-help and online resources

- Crystal Meth Anonymous UK
- London Friend: Crystal Meth
- London Friend: Chemsex
- Budd: App for harm minimisation in chemsex

Sedatives (including benzodiazepines, alcohol, ketamine and opioids) and PTSD/trauma

Key facts: Sedatives

What are sedatives and how do they work?

A sedative drug is a substance that moderates activity and excitement while inducing a calming effect, while hypnotic refers to a substance that causes drowsiness and facilitates the onset and maintenance of natural sleep. The term anxiolytic is sometimes applied to a sedative-hypnotic.

Due to their pharmacodynamic actions, especially the sedative effects, many of the sedative-hypnotics are considered potential drugs of abuse and are therefore regulated as controlled substances. Several sedative-hypnotic drugs have developed a niche in the group of "club drugs" that have become popular in the past decade.

Pharmaceutically produced sedative-hypnotic medications are useful for treatment of a variety of disorders including acute and chronic anxiety, anaesthesia, epileptic seizure control, and insomnia.

Sedative-hypnotic drugs may be divided into three major groups:
1. benzodiazepines
2. barbiturates
3. other drugs that do not fall into either of the first two groups.

The benzodiazepines are frequently classified into three groups:
1. short-acting,
2. intermediate-acting,
3. long-acting.

The duration of action for an individual benzodiazepine plays a major role in determining how that specific drug will be used clinically.

Most pharmacodynamic drug interactions with sedative-hypnotic drugs are easily predictable. Essentially, any other drug that has depressive effects on the CNS will potentially add to the CNS depressive effects of a sedative-hypnotic. In some cases this will simply make the patient more drowsy, more lethargic, or have a significant hangover effect. However, in other cases this interaction may lead to severe effects such as coma and death. Of particular concern in the use of alcohol and opiates with benzodiazepines.

Short-term harms

Most sedatives increase the activity of the inhibitory neurotransmitter gamma-aminobutyric acid (GABA), which causes a decrease in brain activity. Low to moderate doses of sedatives can relieve mild to moderate anxiety and have a calming and relaxing effect. Higher doses of these medications can relieve insomnia and severe states of emotional distress, and result in drowsiness and impaired coordination.

Other short-term effects of sedatives include dilated pupils, slurred speech, irregular breathing, decreased heart rate and blood pressure, loss of inhibition, and impaired judgment, learning and memory. These medications can also cause side effects such as confusion, disorientation, amnesia, depression and dizziness, and, more rarely, agitation and hallucinations. These medications can impair the ability to drive a motor vehicle or operate machinery, especially if they are taken in combination with alcohol or other drugs.

Long-term harms

The long-term effects of sedatives can include chronic fatigue, vision problems, mood swings, aggressive behaviour, slowed reflexes, breathing problems, liver damage, sleep problems and sexual dysfunction.

Long-term use can lead to the development of tolerance, which serves to reduce the effects of the drug and prompts those who use prescription sedatives to increase the dose to reinstate the desired effects. The potential for dependence and substance use disorder increases with repeated use of higher doses.

Long-term regular use of these drugs should be reduced gradually, with medical supervision. People who are physically dependent on a sedative will experience withdrawal symptoms if they stop using the drug abruptly. The severity of withdrawal symptoms depends on the type of medication used, the amount used, the duration of use and whether the drug was stopped abruptly. Withdrawal symptoms can include headache, insomnia, muscle tension, sweating, difficulty concentrating, tremors, sensory disturbances, fear, fatigue, stomach upset and loss of appetite. Severe withdrawal symptoms from regular use of sedatives in high doses can include agitation, paranoia, delirium and seizures.

Special attention should be paid to patients receiving opioid medication therapy as well as sedative-hypnotic therapy. In combination, there is a significantly increased risk of respiratory depression, over-sedation, and accidental overdose death. Prescribers should clearly document the justification for such combination therapy and an evaluation of risk. Prescribers should also consult with their colleagues about these cases. Patients should be offered naloxone rescue kits with instructions and training on their use. Providers should coordinate care with the substance use services prescriber.

Sedatives case study

Patient case

Anita is a 30-year-old woman who lives alone and works part time in a supermarket. She has no children or partner.

Anita was first referred to mental health services by her GP with anxiety attacks, insomnia, nightmares and flashbacks related to a serious incident of domestic violence that occurred 20 months ago.

The perpetrator was her ex-boyfriend and Anita ended the relationship after the assault, which resulted in severe facial injuries and required plastic surgery to reduce scarring.

Shortly after the assault, Anita was given diazepam by a relative to help with anxiety and insomnia, which Anita found helpful. Anita approached her GP to ask for further diazepam but when this request was refused, she started to purchase it online. Anita also started to buy pregabalin online, which a friend told her was "good for trauma".

Over the last 12 months, Anita has been consuming both diazepam and pregabalin daily. The medications "keep me level" and Anita cannot imagine coping without them. She has noticed that the amount she uses has gradually increased and she is currently taking 100mg diazepam and 600mg pregabalin daily.

At assessment, Anita describes herself as being traumatised by the assault and requests help with anxiety, insomnia, nightmares and flashbacks. She is also worried about her use of diazepam and pregabalin, although is embarrassed to discuss this as she knows that the drugs were purchased illegally.

Considerations on initial presentation

Depending on the information within the initial referral and locally agreed processes, assessment could be undertaken by primary mental health or substance use services and should include:

Assess for post-traumatic stress disorder using ICD-11 criteria, including symptoms of anxiety, panic attacks, flashbacks, intrusive memories, hyper-arousal, avoidance behaviours, emotional numbing, insomnia, nightmares, depersonalisation.

Assess substance use using ASSIST-LITE and history, including for diazepam, pregabalin and any other reported substances, the duration of substance use, pattern of use, tolerance, any attempts to reduce or stop, withdrawal symptoms, previous substance use and/or mental health disorders, family history of substance use or mental health disorder.

Urine drug screen to confirm benzodiazepine, pregabalin and other substance use.

Establish whether Anita's circumstances mean she is still in contact with the perpetrator of the assault and, if so, consider involving the police or social services.

Impact on functioning. Is Anita currently able to work? What other impacts do her symptoms have on her daily functioning?

Current support from family/ friends.

Is Anita currently driving?

Longer-term considerations

There is little evidence to support long term prescription of benzodiazepines or pregabalin for the management of post-traumatic stress disorder, although pharmacological options include venlafaxine, SSRIs, risperidone and prazosin.[106] Treatment of PTSD is however primarily psychological, and typically includes specialist trauma therapy.

The continued use of psychoactive substances, such as benzodiazepines is often considered a barrier or even exclusion to accessing trauma therapy, however an assessment of the individual and their specific needs is recommended over blanket exclusions.

Anita describes using diazepam and pregabalin as a way to cope with her PTSD, so careful coordination between substance use services and trauma services is needed, as it may be unrealistic to expect Anita to tolerate PTSD symptoms without alternative strategies.

A gradual reduction in benzodiazepines is indicated as abrupt cessation risks withdrawal symptoms including delirium and seizures, as well as a deterioration in mental health.

Anita may wish to gradually reduce the benzodiazepine dose using her illegally purchased benzodiazepines and pregabalin supply, however substance use services should consider prescribing Anita a tapering supply of both diazepam and pregabalin.

Agree a prescribed Benzodiazepine and Pregabalin reduction plan with an individually determined taper. This would aim to initially stabilise the dose of benzodiazepine and pregabalin before undertaking a gradual reduction determined by Anita's capacity to tolerate withdrawal symptoms.

Benzodiazepines, including diazepam, can be withdrawn in proportions of approximately 10% of the total daily dose every fortnight. In uncomplicated cases of dependence this reduction may be possible more rapidly with regular reviews to monitor progress during the reduction.[107]

In complex cases, for example with significant co-morbid mental health symptoms, the speed of reduction may need to be slowed or even paused to alleviate withdrawal symptoms, before restarting the reduction as a slower pace.[108]

It has been suggested that pregabalin daily dose should be reduced at a maximum rate of 50-100mg/week.[109]

Medication management should be combined with psychological support including relapse prevention and motivational interviewing. Psychological support to manage anxiety is also often indicated.

Urine drug testing may help with monitoring compliance and test for other substances but is not a treatment itself.

Consider close collaboration between substance use and mental health services/trauma therapy services including joint sessions and regular professionals' meetings. Involve, social services and the police as indicated.

Provide emergency contact numbers in case of mental health crisis.

Consider attendance at a women's only part of service with a dedicated worker for such cases

Signpost to local recovery groups/ peer support networks

Involve family in care plan if the person consents to this.

Service structures and how they should function

NICE guideline on Post Traumatic Stress Disorder (NG116)[110] recommendations relevant to this clinical presentation include:

- Where management is shared between primary and secondary care, healthcare professionals should agree who is responsible for monitoring people with PTSD. Put this agreement in writing (if appropriate, using the Care Programme Approach) and involve the person and, if appropriate, their family or carers

- Recommendations for transitions between services include that transitions are planned in advance, involve families and carers, making sure everyone involved in the person's care is aware of their role and responsibility, and ensuring good communication between services, as well as with the person with PTSD.

- Care planning involves a multi stakeholder approach. All services should proceed with a trauma informed care approach. Depending on service structures, a link worker could liaise between mental health services and substance use services with discussion of the case at multidisciplinary meetings to develop a joint care plan crafted and agreed with the patient. This would consist of a biopsychosocial approach.

Key learning

Beware of the risk of rebound anxiety and escalation in PTSD symptoms as the substance use reduces.

A patient with PTSD who is using substances to cope with their symptoms may be unable to reduce and/or stop all illicit drug use due to overwhelming symptoms of PTSD. Supporting the person to develop alternative coping strategies in this case is critical.

All services should work within a trauma-informed approach to care.

Insisting that a patient stops all substance use before they are eligible for trauma therapy can act as a significant barrier to progress in treatment. Early access to supportive psychotherapy, anxiety management, grounding techniques and trauma therapy (and peer support) are as important as pharmacological management of withdrawals.

Self-help and online resources

- PTSD and CPTSD self-help guide
- MIND PTSD self-help
- PTSD useful contacts
- NHS PTSD treatment
- Let's Talk Getting Trauma and PTSD: A Self Help Guide
- RCPsych guidance: Coping after a traumatic event

Opioids and co-occurring mental health disorders

Key facts: Opioids

What is the drug?

- There are two broad group of opioid substances, those that derive directly from opium (e.g. heroin) and those manufactured synthetically (e.g. fentanyl).
- Opioids are full or partial agonists at the brain's opioid receptors, where they block pain signals (and cause a release of dopamine).
- Heroin is made from morphine which comes from the seed pods of the poppy plant. 'Street' heroin in the UK is usually a brown powder.

Prevalence rates:

- Approximately 4.6 in 1,000 people use opioids exclusively while 9.6 in 1,000 people use opioids and crack cocaine combined.[111]
- Nearly half (48%) of all adults attending substance use services are being treated for opioid-related problems. Of this population, 67% also reported mental health issues.[112]
- Just under half of all drug-poisoning deaths registered in 2023 involved an opioid. (46.8%; 2,551 deaths)[113] This is the 12th consecutive annual rise in these deaths.
- Internationally, novel synthetic opioids have caused significant mortality, particularly in North America. In the UK, the number of deaths related to synthetic opioids are much lower than North America, with nitazene rather than fentanyl opioids currently predominating.

How are opioids used?

- Heroin can be smoked, inhaled off heated foil, snorted or injected.
- Some people may inject heroin and crack cocaine, often termed "snowballing" or "speed-balling"
- Prescription opioid medications are available in a range of preparations including tablets, capsules, patches and liquids. When used non-medicinally for their psychoactive effects, these can be swallowed or crushed and snorted or injected.
- Globally, powerful novel synthetic opioid substances including nitazenes and fentanyls are increasingly associated with mortality[105]. They are available in a range of preparations and are often used as adulterants to other drugs, meaning that the user is unaware of what they have consumed.
- The physical and psychological effects of opioids depend on their potency and how they are consumed, with injecting the most dangerous route.
- Dependence to opioids can develop with relatively short periods of continuous use.[114]

Short-term effects:

- A 'rush' of pleasure/euphoria
- Warm flushing of the skin
- Dry mouth
- Heaviness of limbs
- Nausea, itching of the skin and vomiting[115]
- Drowsiness and mental clouding.
- Bradycardia and respiratory depression, which can be life threatening

Long-term effects:

- Physical and psychological dependence with severe withdrawal symptoms. These include
  - Nausea, vomiting, diarrhoea
  - Muscle and bone pain
  - Abdominal and muscle cramps
  - Excessive sweating
  - Restless legs
  - Severe insomnia
  - Agitation and extreme anxiety

These symptoms are best measured using a validated withdrawal scale such as the COWS.[116]

Other long-term effects include:

- Neuronal and hormonal imbalances[117,118] including possible deterioration of the white matter of the brain leading to impaired decision making and emotional regulation & disinhibition of behaviour especially in stressful situations[119].

- Chronic opioid use (more than 1 month), whether prescribed for chronic pain or as treatment for opioid use disorder (OUD), disrupts the hypothalamic-pituitary-adrenal and hypothalamic-pituitary-gonadal axes, potentially leading to hypogonadism, hypoadrenalism, hyperprolactinemia, and osteoporosis.

- Opioids have multiple effects on respiratory physiology, including decreased central respiratory drive, respiratory rate, and tidal volume. They also increase airway resistance and decrease the patency of the upper airways.

- Injecting route is associated with acquisition of blood borne viruses including Hepatitis B, C and HIV, endocarditis, bacterial skin infection and severe vascular disease.

Box 3: Opioid withdrawal

- In the initial titration period, use COWS scoring to establish severity of withdrawal symptoms and to determine appropriate dosing of methadone/buprenorphine. Use local protocols for the management of opioid withdrawals.

- In addition to methadone/buprenorphine, also consider other approaches to managing withdrawals including:
  - anti-emetics, e.g. cyclizine
  - anti-spasmodic, e.g. hyoscine butylbromide
  - analgesia, e.g. paracetamol
  - anti-inflammatories, e.g. ibuprofen
  - psychological approaches to support craving management and relapse prevention

Opioids case study

Patient case

Mike is a 28-year-old man, who has a six-year history of using illicit opioids (heroin) daily. He smokes around £40 worth of heroin each day and has occasionally injected. He has a past history of sexual abuse and trauma after a period in his adolescence when he was coerced into sex working. He stopped this about ten years ago.

Mike presents to the ED with his father who is concerned about Mike. His father reports that Mike has become paranoid, seems to be responding to abnormal perceptions and is washing constantly during the day. He is assessed in ED, medically cleared and referred to the liaison psychiatry team for assessment.

His father reports that he has noticed Mike's mental health deteriorate over the last 2-3 months. There is a family history of paranoid schizophrenia and suicide

Mike has in the past attended substance use services and been prescribed oral methadone but has not been with any service for the last two years and has been using heroin daily instead.

The liaison team decide that Mike needs an informal admission for further assessment but there is a significant wait for a bed to become available. After three hours waiting in the ED Mike starts to become more agitated, yawning, sweating, vomiting and complaining of pain and cramps. He tells you he is withdrawing from heroin and last smoked heroin about four hours ago

Considerations on initial presentation

People dependent on opioids can experience withdrawal symptoms within a few hours of their last use and this is likely to significantly complicated the assessment.

If the withdrawals are not treated quickly, the patient is likely to become increasingly uncomfortable and may feel driven to leave the healthcare setting in order to seek heroin to relieve their withdrawal symptoms.[50]

Opioid withdrawals are best assessed using a validated scale such as the COWS[51] and this will also help with determining clinical management including prescribing decisions.

Establish opioid dependence using the information available to you e.g. a urine drug screen (UDS – testing for opioids and other drugs) combined with the presenting history (including collateral history from other professionals/health records/family if available), physical articles e.g. a methadone bottle with a recent date and the patient's name on, and a COWS assessment.

Emergency Departments sometimes do not have access to point of care urine drug screens. If a UDS is not possible then the key task is establishing whether the patient has clear evidence of current opioid dependence. There are different options for the pharmacological managing of opioid withdrawals, which broadly fall into two group – symptomatic prescribing (e.g. medications to reduce the immediate effects of opioid withdrawal) and substitute prescribing (e.g. prescribing medications which replace the heroin through opioid receptor agonism).

All Acute and mental health providers should have their own hospital policies around how to manage opioid withdrawals including the prescription of appropriate medication. These should be consistent with the national Orange guidelines on drug misuse and dependence.[99, 100]

Considerations on initial presentation (continued)

In the UK, methadone and buprenorphine are the licensed medications used for opioid substitution therapy (OST). A range of medications are licensed for symptomatic management of opioid withdrawal related anxiety, pain, gastro-intestinal upset and insomnia.

It is important to address mental health symptoms (in this case developing persecutory symptoms) and not to assume that these are the result of heroin use. Undertake a risk assessment to exclude suicidal /self-harm risk.

Treat mental health disorders using standard treatment protocols. Do not exclude people who use heroin from mental health protocols on the basis of their drug use.

Offer take home naloxone (the antidote for an opioid overdose) to all current or previously opioid dependent patients prior to discharge from treatment.

People who use opioids experience high levels of stigma. Challenge stigma when it arises and ensure that treatment is not withheld on the basis of having a substance use disorder.

Consider whether the patient is currently driving.

Longer-term exchange

Lifetime prevalence of depression in people with opioid dependence is much higher than in the general population (44-54% versus 16%) and represents a risk factor for morbidity and mortality.[120]

Engaging people with opioid dependence in drug treatment can be life-saving.[121]

Treatment typically includes OST and psychological treatments (including relapse prevention, motivational interviewing) delivered in a trauma informed framework.

Management of depression in people who use opioids should follow evidence based protocols including psychological interventions, medication and behavioural activation. People using opioids should not be excluded from treatment of mental health disorders because of their drug use.

For those prescribed OST there are a number of important issues to address including:

- Methadone can be sedating, while buprenorphine is less so
- There can be interactions with OST and psychotropic medication. For example methadone is sedating and can potentiate the sedative effects of other medications such as benzodiazepines and gabapentinoids.
- Methadone, especially at high doses can lengthen the QTc interval. Caution is needed when prescribing methadone with other medications know to prolong QTc or cause cardia arrhythmias. An ECG is recommended in all patients prescribed greater than 100mg/day of methadone – or where polypharmacy or co-occurring crack cocaine or SCRA use indicates.[122]

Physical health co-morbidities such as COPD and advanced liver disease can increase the risk of accidental overdose

If people are being admitted as an inpatient, staff should be aware of the potential for overdose on the ward or post-discharge and be trained in the use of naloxone.

For people being treated in an inpatient setting, a clear contract should be established about the use of UDS if there is staff suspicion of drug use or following periods of leave from the ward.

Consider risk of co-dependence when prescribing medications such benzodiazepines, Z-drugs and gabapentinoids.

Longer-term exchange (continued)

All clinical staff should feel competent and confident in delivering brief interventions and harm minimisation interventions.

Tolerance to opioids decreases rapidly. Patients who use opioids on discharge are at increased risk of overdose, even if their admission was brief. Patients should, as a minimum, be warned of the risks of overdose and offered overdose prevention advice, provided with take home naloxone and given information on accessing services.

Take home Naloxone and training in its use should be available in psychiatric crisis pathways given that there is roughly an 8-fold risk of drug related death in the first two days following psychiatric admission[123]

Information on needle exchange, drug checking and supervised consumption (Scotland only) should be provided. (Please see Self-Help & Online Resources section at the end)

Be curious and collaborative around the perceived benefits and harms of drug use and the potential interactions with other mental health disorders.

Acknowledge that not everyone who uses drugs will want to stop (or even engage with treatment services), even if there are significant negative consequences. In this situation, it may be possible to support people to reduce the risk of ongoing substance use and to make clear the pathways available if the person seeks help in the future.

Staff and patients should be clear of the need for yearly ECGs (or more frequently) if prescribed antipsychotics/ certain antidepressants and Methadone.

Service structures and how they should function

Involve both substance use and mental health services as soon as possible to facilitate coordination of care.

Opioids dependence and mental health disorders should be treated concurrently.

Supervised consumption of OST is best practice for an initial period of prescribing. This involves the person (once discharged) attending the community pharmacy daily to take their medication under supervision.

The length of time of supervised consumption is determined by the prescriber (usually substance use service) based on clinical safety (key factors will include consumption of other substances (alcohol, sedative medications), physical comorbidities (e.g. COPD), ability to safely store OST medications (e.g. accommodation needs) and risks of diversion.

Key learning

- Opioid use is associated with a high prevalence of mental, physical and social co-morbidities.
- People with opioid dependence will need rapid support with managing opioid withdrawal symptoms if they are to successfully engage in assessment and treatment of mental health disorders.

- Using opioids should not be an exclusion criteria for receiving support for mental health disorders. Standard mental health treatment protocols should be used, with consideration given to the potential risk of interaction between medications and OST (methadone and buprenorphine).

- Even if a person is not considering abstinence or OST, all interactions with health services are an opportunity to deliver brief advice, harm reduction strategies and signpost to community services (e.g. substance use services, narcotic anonymous, needle exchange services).

- Be aware that people using opioids may be particularly sensitive to stigma and negative judgment by professionals, and that this can be a significant barrier to engagement.

- All staff should be trained to deliver brief interventions including harm reduction advice.

- All staff should be trained to provide overdose prevention advice and take home naloxone.

Self-help and online resources

Safe injecting practices:

- The-Safer-Injecting-Handbook
- Getting Off: The Basics of Safer Injection – National Harm Reduction Coalition

General harm reduction around safer using practices:

- Harm reduction – DrugWise
- Basic harm reduction – Release

Naloxone harm minimisation:

- Understanding Naloxone – National Harm Reduction Coalition
- Naloxone – Naloxone Saves Lives

Drug checking:

- City Centre Drug Checking — The Loop

Vulnerable populations

CoSUM disorders encompass a wide range of different mental health and substance use disorders. In addition to this complexity, there are other factors that can make some people more vulnerable to suffering with a CoSUM disorder or more likely to need additional support as part of their treatment. The following section looks at three vulnerable populations, women in the perinatal period, people who experience homelessness and neurodivergent people.

Perinatal mental health and comorbid substance use

Key facts

- Mental health related causes are responsible for nearly 40% of deaths in mothers occurring between 6 weeks and one year after the end of pregnancy. A significant proportion have experienced severe and multiple disadvantage including mental disorder, substance use and domestic abuse.[124]

- Substance use is a risk factor associated with maternal death from direct pregnancy complications in the UK.[125] Additionally, few services are developed to offer antenatal care to people with substance use disorder.

- **Nicotine use in pregnancy:** Smoking tobacco products significantly increases risk for developing miscarriage, stillbirth, prematurity and low birth weight. Helpful guidance to support smoking cessation in pregnancy and beyond can be found on the National Centre for Smoking Cessation and Training (NCSCT) website.

- **Cannabis use in pregnancy:** Smoking cannabis during pregnancy shares or amplifies the health risks associated with smoking nicotine products, but there are additional concerns that cannabis consumed by any method during pregnancy may be associated with behavioural problems in childhood.

- **Alcohol use in pregnancy:** Both the UK and Ireland were among the top five of 187 countries in a global survey of prevalence of alcohol use in pregnancy, which also estimated that one in every 67 women who consumed alcohol during pregnancy would deliver a child with foetal alcohol syndrome.[126] Antenatal alcohol exposure is a leading preventable cause of birth defects and developmental disabilities and also increases risks of spontaneous abortion, stillbirth, weight and growth deficiencies, birth defects and prematurity.

- **Opioid use in pregnancy:** Substance use services not only treat people who are dependent on heroin but also those who have become dependent on a range of opioids including oxycodone, tramadol, fentanyl, codeine and dihydrocodeine. In some cases, these medications were initially prescribed for pain, while others have accessed these drugs through illegal means. If the pregnant woman is opioid dependent, then in most cases the best approach is to stabilise the patient on

long-acting opioid substitute treatment, usually methadone but sometimes buprenorphine, and to maintain the patient on this treatment throughout pregnancy. If substitute treatment is used, it should be the lowest effective dose, especially near term, to minimise neonatal withdrawal.

- **Benzodiazepine use in pregnancy:** Data on benzodiazepine use is confounded with older studies identifying an increased risk of congenital malformation, specifically orofacial clefts and cardiac malformation. Recent more robust studies have failed to identify such associations. Abrupt withdrawal of diazepam is not recommended as this may destabilise the maternal condition. Neonatal withdrawal and /or 'floppy baby syndrome' is a risk with prolonged use near term, especially at high doses. It is advised to monitor for neonatal respiratory depression.

- **Cocaine use in pregnancy:** Data on cocaine use is confounded, however cocaine use during pregnancy has been associated with increased risk of spontaneous abortion, placental abruption, premature labour, intrauterine growth retardation and sudden infant death syndrome (SIDS). The teratogenicity of cocaine is not confirmed; however, malformations have been observed in infants. Exposure in late pregnancy may lead to neonatal withdrawal in the infant.

- **Amphetamine use in pregnancy:** Due to confounding factors, for example contamination, use of other drugs or alcohol, it is difficult to provide any firm conclusions about the risk to the developing foetus. An increased risk of preterm delivery, foetal growth retardation and low birth weight have all been suggested to be associated amphetamine use, with an increased risk of neonatal withdrawal if use is sustained throughout or used in late pregnancy. It has been hypothesised that amphetamine use may be associated with neurodevelopmental delay, but due to limited data it is not possible to assess causality.

Considerations to make for this group

- A thorough assessment is needed, which does not just consider current presentation.

- If a patient presents in early pregnancy, do not make major changes to medication, unless they are prescribed a known teratogen such as sodium valproate or carbamazepine, in which case it is important to seek expert advice as soon as possible to review and change medication plan. Otherwise follow general principles of prescribing in the perinatal period and seek advice from local perinatal and drug and alcohol services.

- Recognise the importance of trauma history in assessment of risk. Becoming a parent can be associated with a significant worsening of mental health and associated increased risk. Consider ongoing chronic stress such as domestic abuse, housing and poverty which can impact on birth and infant outcomes.

- New expressions or acts of violent self-harm, estrangement from infant and persistent thoughts of incompetence as a mother are 'red flag' symptoms and should always be taken seriously.[127] Access to services such as ED, liaison, crisis and home treatment teams should be considered alongside referral to perinatal services for advice and assessment as needed.

- Sensitively enquire about mental health, domestic abuse and substance use. The assessor needs to be mindful as to why a woman may not share information. It is important to be alert to the impact of stigma and fear of child removal. This may influence a women's willingness to disclose symptoms of mental illness, self-harm or substance use, with a risk of under-reporting.

- Be aware of women who conceal their pregnancy, present late or engage poorly, with antenatal care.

- For the majority of women with substance use, safeguarding considerations will need to be made, including whether a referral to Children's Services is required. Many other factors can also influence parenting capacity, including poverty, poor housing, domestic abuse, and mental health difficulties. An assessment should be undertaken that takes these additional factors into account. Coordinated care across multiple agencies will be essential, with a clear plan outlining roles, responsibilities, and who is leading the care coordination.

- Standard universal care, in place of personalised care, may result in disengagement and poorer outcomes for women. They should receive enhanced midwifery care to provide continuity, with coordinated care tailored to women's needs across services and agencies.

- Discuss nutrition regarding vitamins and general diet during pregnancy. A gynaecological history prior to pregnancy may be a useful indicator regarding weight and nutritional status.

- Physiological change from 26 weeks onwards can cause reduced efficacy of psychotropic medications and needs to be carefully considered e.g. prescribing of antipsychotic, mood stabilisers and opioid substitution treatment.

- Consider potential obstetric risk to foetus (for example growth restriction, placental abruption, low birth weight, neonatal withdrawal and respiratory depression) with close liaison with obstetrics to reduce risk and harm. Additional monitoring may be required.

- Be aware of any change in the nature or frequency of presentation as this may indicate new or increased substance use or other complications e.g. domestic abuse. This is particularly important for women experiencing multiple mental, physical and social challenges. If a change in presentation is detected, then reassessment and reformulation of the treatment plan is indicated.[128]

- Women are often at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Professionals should ensure that women who have been involved with substance use services prior to or during pregnancy, should be offered review for re-engagement in the early postnatal period.

- Women facing child removal and following child removal are at higher risk of relapse and suicide. This is also likely to be a particularly difficult time to maintain engagement, compounded by some services withdrawing when the woman does not have parental responsibility.

- Collaborative care planning is needed particularly where there is a risk of neonatal withdrawal. If multiple services are involved, it will require multiple professional meetings.

- Ensure clear communication and information sharing, as different IT systems are used across the care pathway.

- Consider women with past history of 'drug induced psychosis' potentially at increased risk of postpartum psychosis.
- Consider drug/alcohol screening including UDS.
- A low threshold should be adopted for admitting pregnant women who may be dependent on alcohol to hospital for assisted withdrawal from alcohol. Benzodiazepine use by the mother at the time of delivery can result in "floppy infant syndrome" or neonatal withdrawal symptoms and so the prescribing principle should be the lowest dose for the shortest time possible.[129]
- The management of opioid dependence in pregnancy should be undertaken in collaboration with a senior prescriber who has the required competences and in line with best practice. Involving substance use services is strongly recommended.[130]

Additional resources

Detailed guidance on the assessment and management of drug use, including guidance on drug use in pregnancy and beyond, has been produced by the Departments of Health across the UK (Department of Health 2017) More specific resources on substance use in pregnancy can be accessed online from NHS Scotland, the World Health Organization (2014) and the US based Substance Abuse and Mental Health Services Administration (SAMSHA) , CDC Centres for Disease Control and Prevention, and the National Institute on Drug Abuse (NIDA).

Homelessness

Key facts

- The number of people sleeping rough has increased in recent years: 4,677 people were found to be sleeping out in England in the annual 'street count' in November 2024 (an increase of 20% since 2023).[131]
- The above is on top of other forms of homelessness such as 'statutory homelessness' (298,430 households in England were assessed as owed a homelessness duty by their Local Authority in 2022-23).[132] There is also 'hidden homelessness', which includes situations such as when an individual is sofa-surfing or squatting.
- In Scotland, 33,619 households were assessed as homeless in 2023-24,[133] and 1,916 of these reported rough sleeping the night before making a homeless application.[134] Wales and Northern Ireland have lower rates of rough sleeping, with the latest estimated figures being 173[135] and 72[136] respectively.
- Rates of substance use are hard to establish but appear to be higher than in the general population. For people sleeping rough, estimates of drug and alcohol use are between 40 and 60%.[137, 138] Patterns and trends in drug use vary in different areas across the UK.
- Rates of mental illness are also high: in one study by Homeless Link in 2022,[139] 82% of respondents reported having a mental health diagnosis. A report by Crisis in 2009 noted rates of 'serious mental illness' (severe depression, bipolar, schizophrenia) to be at 25-30%.[140]
- In 2021, 35% of deaths among homeless people in England and Wales were related to drug poisoning and 9.6% were alcohol related. Suicide accounted for 13.4% of deaths. The mean age of death for homeless males was 45, and for homeless females was 43.[141]
- Trimorbidity, i.e., the combination of physical ill-health, substance use and mental illness, is common. Over 60% of homeless people report a long term physical illness or disability.[142] Rates of COPD are 15 times higher than in the general population, and rates of heart disease 6 times higher.[143] Physical complications of injecting drug use, such as bacterial infection and blood borne viruses, are also relatively common: Hepatitis C, for example, is 50 times more prevalent in homeless populations.[144]

Considerations to make for this group

- Homeless people may find it hard to access mainstream services for many reasons. Some of these are practical, including: lack of access to the internet, lack of mobile phones, appointment letters going to out of date addresses, difficulties with literacy. Not being registered with a GP may be a barrier to secondary care (but note that ID is NOT required to register with a GP).
- Stigma, previous bad experiences with health professionals or authority figures, fear, and prioritisation of other needs may also lead to ambivalence about seeking care.

- Bear in mind that trauma may underlie homelessness, mental illness, and drug use, and the relationship between these is complex. All care offered should be trauma informed. Relationships are key, and respect and compassion essential.
- As homeless people often experience trimorbidity, be alert to the likelihood that there are multiple needs. Try to treat the person holistically: the more interventions that can be offered in one setting, the better.
- It is very difficult to make changes to substance use, or to treat mental illness successfully, without adequate housing. Advocate for the person's right to a home.
- If you are concerned about someone you have seen sleeping rough, the quickest way to get them help is through StreetLink: www.thestreetlink.org.uk

Additional resources

NICE Guideline 214, published in March 2022, covers providing Integrated Health and Social Care for People Experiencing Homelessness. Other sources of information on health care for people experiencing homelessness include Pathway (the homeless and inclusion health charity), and Homeless Link.

Certain public bodies, including EDs and inpatient hospital wards, have a duty to "identify and refer a service user who is homeless or may be threatened with homelessness, to a local housing authority of the service user's choice". Information on how to do this can be found here: Homelessness code of guidance for local authorities - Chapter 3: Advice and information about homelessness and the prevention of homelessness.

Patients with neurodivergence

Autism: Key facts

- Although findings differ according to location and population studied, there is some evidence to suggest that autistic adults are at higher risk of alcohol use disorders and drug use disorders.
- While autistic people are less likely to drink, those who do drink are more likely to develop alcohol dependence.
- There is also evidence of an elevated prevalence of behavioural addictions (gambling and internet addiction).[145]
- The risk is raised further where there is comorbid autism and ADHD.[146]
- Those autistic people who do use alcohol or drugs are more likely to report use as a coping strategy e.g. to reduce social anxiety.
- People with autistic traits such as rigidity and social communication difficulties and alcohol dependence had a higher chance of continued drinking following treatment at 2 years follow-up than those without.[147]

Attention-deficit/hyperactivity disorder (ADHD): Key facts

- Adult ADHD often co-occurs with substance use disorders (SUD)
- It is associated with early onset and more severe development of SUD and with reduced treatment effectiveness.
- Consider screening with validated tools of ADHD in SUD populations, followed by an ADHD diagnostic assessment as indicated.
- Simultaneous and integrated treatment of ADHD and SUD, using a combination of pharmaco- and psychotherapy, is recommended.
- Long-acting methylphenidate, extended-release amphetamines, and atomoxetine with up-titration to higher dosages may be considered in patients unresponsive to standard doses.

Considerations to make for this group

To address social communication differences:

- Have a clear explanation of what support is offered at the service available in different formats – e.g. written, audio and video
- Have ways of communicating about appointments that do not require phone calls, e.g. emails and texts
- Where possible communicate via the patient's chosen medium

- Be explicit about the purpose of the meeting and the possible outcomes
- Explain your role and the nature of your relationship to the patient
- Set an agenda together
- If the patient would like to discuss a special subject of their interest, allocate time to it towards the end of the agenda
- Use plain English and avoid the use of figurative language
- Give the patient written information to take away to allow for processing and arrange further calls or emails for clarification where needed
- Autistic people can do well in groups where there is a clear structure. If accessing group psychosocial interventions, it may be helpful for them to meet the facilitator and to see the room ahead of time, and to have available a document with FAQs for their review.
- Autistic people may have alexithymia where they struggle to recognise and describe their emotional states. Use of 'zones of regulation' to guide them may help with this, e.g. in elucidating internal triggers to use.

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